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Vol. 28 No. 52

Kaapstad, 25 Desember 1954
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IN THIS ISSUE — IN HIERDIE UITGAWE

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1. Council on Pharmacy & Chemistry: New and Nonofficial Remedies 1953, Philadelphia, J. B. Lippincott Co., 1953, p. 252.

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# Christmas Greetings from the President

*Dr. L. E. Lane, the President, sends the following message of greeting for Christmas and the New Year to members of the Association:*

*It is my pleasant privilege to send a message of Goodwill and Christmas Greetings to all my colleagues.*

*I hope that during the Festive Season you will all have time to enjoy a full measure of happiness in your homes and that in the coming year our Association will receive your active support and co-operation.*

*A Merry Christmas and a prosperous New Year to you all.*

# Kersgroete van die President

*Die President, dr. L. E. Lane, stuur die volgende boodskap van Kersgroete en Nuwejaarswense aan lede van die Vereniging:*

*Dit is my 'n aangename voorreg om aan al my kollegas Kersgroete te stuur en hul alles van die beste toe te wens.*

*Ek hoop dat elkeen van u die geleentheid sal kry om saam met u familie die feestyd terdeë te geniet, en dat ons Vereniging in die nuwe jaar op u aktiewe ondersteuning en samewerking kan staatmaak.*

*Gelukkige Kersfees en voorspoedige Nuwejaar.*

## VAN DIE REDAKSIE

### PROBLEME i.v.m. AORTAKLEPVERNOUING

Die geslaagde chirurgiese behandeling van sommige gevalle van mitraal- en longstenose het hartchirurge aangespoor om aandag aan aorta-stenose te bestee. Horace Smithy, 'n baanbreker op die gebied van hartoperasies, is op 'n jeugdige ouderdom as gevolg van aorta-stenose oorlede. Dit het as spoorslag vir sy kollegas gedien en in 1952 het C. P. Bailey en sy medewerkers [1] van Philadelphia die eerste verslae oor geslaagde aorta-valvotomies gelewer. Hul het 'n linkerkamersnit gemaak en die saamgegroeide aortaknobbels met 'n spesiale verwyder oopgesplits. Daarna is verslae deur Logan en Turner [2] van Edinburgh en Cooley en de Bakey [3] van Texas gedoen oor klein reekse gevalle

## EDITORIAL

### THE PROBLEM OF AORTIC STENOSIS

The success which has attended the operative treatment of some cases of mitral and pulmonary stenosis has prompted cardiac surgeons to turn their attention to stenosis of the aortic valve. The untimely death from aortic stenosis of Horace Smithy, a pioneer in cardiac surgery, spurred on his colleagues, and C. P. Bailey and his team [1] from Philadelphia were (in 1952) the first to report successful aortic valvotomies. This they achieved by introducing a special dilator through a left ventricular incision and splitting apart the fused aortic cusps. Subsequently Logan and Turner [2] from

wat op dieselfde manier behandel is met ‚bemoedigende resultate'.

Ten spyte van die leemte in amptelike literatuur is dit welbekend dat hartchirurge in alle dele van die wêreld geskikte gevalle vir operasies uitsoek. Dit het daartoe gelei dat vraagstukke wat tot nog toe suiwer akademies was nou gewigtige praktiese probleme is. In 1954 het Jordaan en Muller [4] op die Suid-Afrikaanse Mediese Kongres verslag gedoen oor aorta-stenose-operasies.

Daar moet nog lig gewerp word oor die etiologie van aorta-stenose. Partykeer is dit erflik maar onder volwassenes is die letsels in die meeste gevalle verworwe. Dit is duidelik dat rumatiek die oorsprong is van aorta-klepvernouing wat met verswakking of met mitraal-letsels gepaard gaan; maar oor die oorsprong van die egte aortaklepvernouing het 'n strydvraag ontbrand. Die klinies-patologiese studies van Karsner en Koletsky [5] en van Kumpe en Bean [6] dui daarop dat die oorsprong van die meeste gevalle by rumatiek-koors gevind kan word. In Engeland kon Kiloh [7] en Lewes [8] egter geen dergelike etiologie by hulle gevalle vind nie. Waarskynlik sal hierdie probleem net deur uitgebreide navorsing opgelos word—soos bv. die groot projek van Bland en Jones (1951) in Boston; hul is tans besig om die geskiedenis van 1,000 rumatiekkoorsgevalle te bestudeer. Na 20 jaar is egte aortaklepvernouing by slegs 2 van hul pasiënte waargeneem en Bland en Jones opper die mening dat letsels net by erflike tweeslippige kleppe ontwikkel.

Die kliniese tekens van egte aortaklepvernouing is net so verborge. Sir Thomas Lewis se drie tekens[9] (basale sistoolgeruis, trilling, en 'n hefpols) is in die meeste gevalle afwesig. Deesdae word 'n hefpols selde teëgekom; die aanwesigheid daarvan getuig egter van ernstige vernouing. Sistool-trilling kom slegs by 'n derde van die gevalle voor wat Kumpe en Bean en Lewes beskryf het; die aanwesigheid daarvan korreleer nie met die graad van vernouing nie. Leathem [10] het met behulp van die fonokardiograaf die diamantkonfigurasie van die sistoolgeruis gedemonstreer en getoon dat dit voor die tweede klank eindig, maar daar is gevalle waar die sistoolgeruis slegs by die hartpunt gehoor word en gevalle met geen sistoolgeruis hoegenaamd nie. Basale diastoolgeluide mag op 'n vroeë stadium voorkom en mag hard wees selfs as daar geen verswakking is nie en alhoewel die geluid van 'n aorta wat toegaan kenmerkend sag of afwesig is, mag die toon selfs in gevalle van ernstige stenose geen verandering ondergaan nie.

Die elektrokardiogram dui miskien geen abnormaliteite aan nie; veranderings, wat aan linkerkamer-hipertrofie en aan relatiewe subendokardiaal-ischemie te wyte is, word slegs op 'n gevorderde stadium geopenbaar. Radiologies dui linkerkamer-hipertrofie ook 'n gevorderde stadium aan maar klepverkalking en na-stenose-uitsetting van die opstygende aorta is uiters belangrike diagnostiese tekens.

As die bevestigde diagnose 'n operasie aandui, skep dit weer 'n ernstige waagstuk. In teenstelling met mitraalstenose word aorta-stenose-pasiënte eers op gevorderde ouderdom deur die letsel aangetas. Tekens van dispnee, hartpyn en serebraal-ischemie verskyn

Edinburgh and Cooley and de Bakey [3] from Texas have reported small series of similarly treated cases with 'encouraging results'.

Despite the paucity of official publications, it is well known that cardiac surgeons the world over are selecting suitable cases on which to operate. As a result a number of hitherto academic problems have assumed considerable practical importance. Jordaan and Muller [4] reported at the South African Medical Congress of 1954 on cases operated on for aortic stenosis.

The aetiology of aortic stenosis is not yet clear. Some cases are congenital, but in most adult cases the lesions appear to be acquired. Aortic stenosis with incompetence or with associated mitral lesions is clearly of rheumatic origin, but it is round the cases of pure aortic stenosis that the controversy has raged. The clinico-pathological studies of Karsner and Koletsky [5] and of Kumpe and Bean [6] have suggested that rheumatic fever is the cause in most cases. In England, however, Kiloh [7] and Lewes [8] have been unable to demonstrate a similar aetiology in their cases. The solution to this problem may only come from long-range studies—like the great project of Bland and Jones (1951) in Boston, who are studying the natural history of 1,000 cases of rheumatic fever. At the end of 20 years, only 2 of their patients had pure aortic stenosis and Bland and Jones suggest that this lesion only develops on congenitally bicuspid valves.

The clinical signs of pure aortic stenosis are no less obscure. Sir Thomas Lewis's triad [9] (basal systolic murmur, thrill, and an anacrotic pulse) is not present in most cases. The anacrotic pulse is not often found by modern clinicians; its presence, however, is evidence of tight stenosis. Only a third of the cases described by Kumpe and Bean and by Lewes had a systolic thrill, and its presence does not correlate with the degree of stenosis. Leathem [10] has shown with the phonocardiograph that the systolic murmur is of diamond configuration and ends before the second sound, but there are cases with only apical systolic murmurs and some with no murmurs at all. Early basal diastolic murmurs may occur and may be loud despite the absence of incompetence, and although the aortic closing sound is characteristically soft or absent it may be unaffected even if the stenosis is severe.

The electrocardiograph may show no abnormality; changes due to left ventricular hypertrophy and to relative subendocardial ischaemia only occur as late manifestations. Radiologically, too, left ventricular hypertrophy is a late sign, but calcification of the valve and post-stenotic dilation of the ascending aorta are valuable diagnostic signs.

Once the diagnosis is established, indications for surgery present another major problem. Unlike those with mitral stenosis, patients with aortic stenosis are generally unaffected by the lesion till late in life. Symptoms of dyspnoea, cardiac pain and cerebral ischaemia often appear only after middle age and then the course

dikwels eers ná middeljarige leeftyd en dan is dit snel progressief. As gevolg van ouderdom, linkerkamerhipertrofie en miokardiaal-ischemie hou die operasie groot risiko's vir hierdie pasiënte in. Bailey [11] (1954) vind die hartspier bros en prikkelbaar met ondoeltreffende bloedstelping en kamertrilling as ernstige risiko's. Aan die ander kant is 'n operasie sekerlik nie gewens vir die jong pasiënt nie wat simptoomvry is en wat 'n ryp ouderdom mag bereik of aan 'n heeltemal onverwante kwaal mag beswyk. Bailey hoop om die operasie veiliger te maak deur middel van 'n dwarsaortasnit wat hy onlangs bedink het. Hy verkies om nie te opereer nie as daar enigsins taamlik verkalking is alhoewel Logan en Turner nie hierdeur afgeskrik word nie. Vir diegene egter wat lykskouingstudies van ‚aortic nodular sclerosis' gemaak het, kom dit voor dat geen verwyder sommige van die ergste verkalkte kleppe uiteen kan skeur nie.

Die vernuf en ondernemingsgees wat hartoperasies openbaar kom die hoogste lof toe, maar ten slotte is ons kennis van aortaklepvernouing nog onvolledig en aansienlike navorsing is nog nodig alvorens aortavalvotomie 'n uitgemaakte prosedure word. Tot dan moet die operasie as eksperimenteel beskou word en moet dit beperk word tot 'n paar spesiale navorsingssentrums.


1. Bailey, C. P., Redondo-Ramirez, H. P. en Larzelere, H.B. (1952): J. Amer. Med. Assoc., **150,** 1647.
2. Logan, A. en Turner, R. (1954): Lancet, **1,** 1901.
3. Cooley, D. A. en de Bakey, M. E. (1954): J. Amer. Med. Assoc., **155,** 235.
4. Jordaan, M. en Muller, H. (1954): S. Afr. Tyd. vir Geneesk., **28,** 771.
5. Karsner, H. T. en Koletsky, S. (1947): *Calcific Disease of the Aortic Valve.* Philadelphia en Londen: J. B. Lippincott Co.
6. Kumpe, C. W. en Bean, W. B. (1948): Medicine (Baltimore), **27,** 139.
7. Kiloh, G. A. (1950): Brit. Heart J., **12,** 33.
8. Lewes, D. (1951): Brit. Med. J., **1,** 211.
9. Lewis, T. (1940): Diseases of the Heart. Londen: MacMillan and Co. Ltd.
10. Leatham, A. (1951): Brit. Heart J., **13,** 153.
11. Bailey, C. P., Bolton, M. E., Jamison, W. L. en Nichols, H. T. (1954): Circulation, **9,** 22.


is rapidly progressive. By then, because of their age, the left ventricular hypertrophy and the myocardial ischaemia, these patients are poor operative risks. Bailey,[11] writing this year, records that he has found the myocardium to be friable and irritable, with inadequate haemostasis and ventricular fibrillation as serious hazards. On the other hand operation is hardly indicated in an asymptomatic young patient who may well live to a ripe old age or die from some unrelated condition. Bailey hopes to increase the safety of the procedure by a trans-aortic approach which he has recently devised. He prefers to avoid cases with more than slight calcification of the valve, although Logan and Turner have not been deterred by this. To those, however, who have studied necropsy specimens of 'aortic nodular sclerosis' it would appear that any dilator would be inadequate to disrupt some of the more heavily plastered cusps.

Great admiration is evoked by the skill and the enterprise of cardiac surgery, but it must be concluded that our understanding of aortic stenosis is incomplete and that considerable investigation will be necessary before aortic valvotomy becomes an established procedure. Until then, the operation should be regarded as experimental, and its performance limited to a few special centres of research.


1. Bailey, C. P., Redondo-Ramirez, H. P. and Larzelere, H. B. (1952): J. Amer. Med. Assoc., **150,** 1647.
2. Logan, A. and Turner, R. (1954): Lancet, **1,** 1091.
3. Cooley, D. A. and de Bakey, M. E. (1954): J. Amer. Med. Assoc., **155,** 235.
4. Jordaan, M. and Muller, H. (1954): S. Afr. Med. J., **28,** 881.
5. Karsner, H. T. and Koletsky, S. (1947): *Calcific Disease of the Aortic Valve.* Philadelphia and London; J. B. Lippincott Co.
6. Kumpe, C. W. and Bean, W. B. (1948): Medicine (Baltimore), **27,** 139.
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11. Bailey, C. P., Bolton, M. E., Jamison, W. L. and Nichols, H. T. (1954): Circulation, **9,** 22.


## ASPIRIN POISONING

Aspirin (acetylsalicylic acid) is today one of the commonest of household medicines. An idea of the extent to which it is used may be gained from the amount of advertising undertaken by different firms anxious to get as large a share of the market as possible. It is a useful and effective household remedy provided it is used with intelligence and care, which are especially necessary if it is administered to young children, and it is extensively prescribed by medical practitioners.

Several types of aspirin (or salicyl) poisoning are described.[1] There are the cases in which large quantities of aspirin tablets are taken (generally by women) in suicidal attempts or as a suicidal gesture, usually, though not always, without a fatal result. Then there are the cases in which quantities of aspirin tablets are accidently swallowed—practically always by small children, who mistake the tablets for 'sweets'. Fortunately these cases, again, are usually not fatal; but fatal cases are on record. Lastly, there is the group (even more preventable than the 'accidental' group), chiefly infants and young children, in which an overdose of aspirin is given as the result either of medical prescription or parental dosing.

Deaths of young children from salicylate poisoning occur more commonly from repeated doses than from single large doses. Because of the immature state of the kidneys the salicylate is excreted more slowly than in adults, which leads to its accumulation ('pyramiding' is the American word) in the bloodstream.[2]

A paper by Dr. Seymour Heymann and his colleagues,

published in this number of the *Journal* (page 1092) deals with the subject. They record 15 cases of salicylate poisoning, of which 7 were fatal, seen in one year at the Transvaal Memorial Hospital for Children, Johannesburg, all resulting from the administration of salicylate 3 or 4 times a day (most commonly sulphonamide-aspirin mixtures) to infants under 2 years old.

It is very obvious that medical practitioners ought to be alive to the danger inherent in prescribing aspirin in repeated doses to young children. Heyman *et al.* point out that whereas the customary dose of acetylsalicylic acid for infants is taken as 1 gr. for each year of age, fatalities occur in the 1½–3 gr. range. The margin between the optimal and the lethal dose (as far as these can be laid down) is therefore uncomfortably close.

For this reason, the early picture of deafness, giddiness and tinnitus should be borne in mind whenever aspirin is prescribed for a young child. Hyperventilation was seen at a more advanced stage in nearly all their cases, and the authors emphasize strongly the importance of salicylate intoxication in the differential diagnosis of this alarming physical sign. Hyperpyrexia, convulsions and a history of repeated doses indicate a grave prognosis.

Since most cases of salicylate poisoning are due to lack of foresight—either on the part of the parent in failing to keep the home medicines out of the children's reach or dosing them immoderately, or on the part of the medical attendant in prescribing the drug for repeated administration—we commend this article to the attention of our readers.

1. Editorial (1953): J. Pediat., **42**, 276.
2. Editorial (1953): Amer. J. Dis. Child., **85**, 58.

# SALICYLATE OVERDOSAGE AND INTOXICATION IN INFANTS AND YOUNG CHILDREN

SEYMOUR HEYMANN
S. N. JAVETT
A. M. RUDOLPH*
*Transvaal Memorial Hospital for Children, Johannesburg*

Salicylate, generally in the form of aspirin, is widely used as an analgesic and antipyretic both by doctors and laymen. When properly used it is an eminently useful drug; improperly used, it may be dangerous. Although it is realized that large doses of salicylate may be poisonous, the symptoms of toxicity are not generally recognized. Most cases of overdosage in adults are due to suicidal attempts, and only a few due to ingestion of large amounts to allay pain. In childhood the great majority of cases of overdosage occurs after accidental ingestion in the form of aspirin (acetylsalicylic acid) tablets. The relative infrequency of fatality after massive ingestion, either suicidal or accidental, was stressed by Krassnoff and Bernstein [1] in 1947: they reported a fatal case of aspirin poisoning, and their review of American literature revealed only 7 previously-reported deaths of this nature. Balázs [2] reported 752 cases with 4 deaths for the period 1924-1929 in Budapest. A minority of the cases is due to therapeutic administration, and it is with this calamity that we are mainly concerned.

It is the purpose of this paper to call attention to the frequency with which toxic symptoms due to salicylates occur, particularly in infants and very young children, and to stress the common presenting manifestations of toxicity. The material is derived from admissions to the Transvaal Memorial Hospital for Children, Johannesburg, and consists of two groups—the first seen over an 8-year period, comprising 26 infants and children who had ingested a single large dose of salicylate (usually aspirin) without resultant mortality; the second consisting of 15 cases of salicylism in infants under 2 years of age encountered during a 1-year period (1951), in whom the salicylate had been administered therapeutically every 4-6 hours, generally in the form of sulphonamide-aspirin mixtures. In this latter group there were 7 deaths, 5 occurring in infants taking such a mixture.

The illnesses for which the drug was given were in the main catarrhs of the upper respiratory tract, diarrhoea and minor upsets attributed to teething. The symptomatology of salicylism was to some extent confused by the symptoms of the illness for which aspirin had been administered, and in the same way assessment of the part played by salicylism in the mortality must make due allowance for the contribution by the underlying disease.

## DOSAGE AND TOXICITY

*Dosage.* The dosage schedule in infants and children has not yet been adequately assessed, in spite of the long period over which the drug has been used. Lipman *et al.*[3] maintain that a dose of 0.09 g. (1½ gr.) per kg. should not and need not be exceeded for therapeutic effect. Marriot and Jeans [4] state that the usual recommended dose in children is 1 grain per year of age, and if it is repeated 4-hourly, a maximum of 6 grains per 24 hours may be used and should on no account be exceeded. These amounts are considerably less than those frequently used in medical practice, and even at this level may be injurious under certain circumstances.

Most cases of overdosage and poisoning have been associated with either aspirin or sodium salicylate, but

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occasionally accidental poisoning with methyl salicylate (oil of wintergreen) occurs.

*Toxic Manifestations*

The adult, or the child who is old enough, first experiences subjective feelings of tinnitus, deafness and vertigo, often with nausea and profuse perspiration. These symptoms are not usually severe and are not generally regarded as serious toxic effects. Manchester [5] ignored them in salicylate therapy and was only concerned with more serious noxious effects. Jager and Alway [6] found that nausea, vomiting and acneiform eruptions which were noted early in the course of therapy disappeared with continuation of the drug.

The more serious manifestations—usually the first evidence of toxicity in infants and younger children—are thirst, persistent vomiting, pyrexia, hyperventilation, and irritability proceeding to delirium. Restlessness and air hunger may be extreme. The over-all clinical picture is one of 'pneumonia without physical signs'; death is frequently preceded by convulsions. Vomiting may be due to gastric irritation by the drug, which frequently causes marked congestion of the gastric mucosa with petechial haemorrhages. Persistent vomiting, however, is probably due to a central effect, for Graham and Parker [7] have shown that this symptom may occur when the drug is administered rectally or intravenously.

Hyperventilation is important and significant evidence of toxicity, and certainly in infants it is the most prominent clinical feature of salicylism. The cause of this symptom has been the subject of much comment and investigation: several authors [8-11] believed the underlying factor to be acidosis leading to hyperpnoea as a secondary compensatory effect. However, it is now believed that salicylates cause primary stimulation of the respiratory mechanism, which results in respiratory alkalosis.[12-17] An excretion of bicarbonate in the urine follows, producing an alkaline urine, and a compensated state with lowered $CO_2$-combining power results.[7] This state is presently disturbed by an unexplained addition of ketones to the blood, resulting in severe ketosis. Starvation and vomiting increase the process. Finally, the respiratory centre fails and muscular fatigue occurs, hyperventilation ceases, and an uncomplicated acidosis is the outcome. An understanding of these physiological aberrations is necessary in the approach to treatment, which consists in great part of correcting electrolyte imbalance.

*Relationship of Dosage to Toxicity*

A study of Tables I and II shows that the incidence and severity of toxic effects is not proportionate to the amount of the drug ingested. In the group of 26 cases where salicylate was taken accidentally in a single large dose by a previously healthy child, only 3 cases manifested signs of evanescent toxicity, the remainder being asymptomatic. This group comprised older children, only 7 being under 2 years of age and only 2 under one year. The amount ingested varied from just over 1 gr. per lb. of body weight to as much as 7 gr. per lb.; in most cases it was about 1½-2 gr. per lb. In the 3 cases which showed toxic signs, the amounts were 7½ gr.

TABLE I. INFANTS AND CHILDREN RECEIVING A SINGLE LARGE AMOUNT OF SALICYLATE

| *No.* | *Name* | *Age (years)* | *Weight (lb.)* | *Dose taken (a)* | *Symptoms* | *Onset after dose* | *Salicyl level (mg.%)* |
|---|---|---|---|---|---|---|---|
| 1 | B.C. | 3 | 31 | 80 grs. | None | — | Not done |
| 2 | P.F. | 2½ | 28½ | 120 grs. | Vomited once | — | 52 |
| 3 | K.B. | 3 | 33 | 60 grs. | None | — | Not done |
| 4 | S.K. | 2½ | 29 | 50 grs. | do. | — | 51 |
| 5 | B.P. | 1⁸/₁₂ | 21 | 2-3 drachms | do. | — | 17 |
| 6 | D.B. | 4 | 38 | ? | do. | — | 27 |
| 7 | P.P. | 1¾ | 24 | 60 grs. | do. | — | Not done |
| 8 | J.T. | 3 | 36 | 95 grs. | do. | — | do. |
| 9 | A.D. | 2¹¹/₁₂ | 34 | 100 grs. | do. | — | do. |
| 10 | T.S. | 2⁷/₁₂ | 30 | 40 grs. | do. | — | do. |
| 11 | L.J.V. | 3 | 33 | 250 grs. | Profuse vomiting. Hyperventilation (*b*) | ± 36 hrs. | do. |
| 12 | E.C. | 2¹/₁₂ | 29 | 44 grs. | None | — | do. |
| 13 | R.W. | 3½ | 32 | 170 grs. | do. | — | do. |
| 14 | J.S. | 3 | 31 | 60 grs. | do. | — | do. |
| 15 | R.C. | 3 | 29½ | 70 grs. | Drowsiness. Vomiting for 48 hrs. (*b*) | ± 36 hrs. later | do. |
| 16 | D.H. | 2½ | 29½ | 80 grs. | None | — | do. |
| 17 | N.R. | 2¹/₁₂ | 30 | 48 grs. | do. | — | do. |
| 18 | C.H. | 4⁸/₁₂ | 36 | 125 grs. | do. | — | do. |
| 19 | M.P. | 1¹⁰/₁₂ | 27 | 75 grs. | Irritability. Drowsiness. Hyperventilation (*b*) | ± 24 hrs. later | do. |
| 20 | P.B. | 1⁸/₁₂ | 25 | 30 grs. | None | — | do. |
| 21 | S.P. | 5½ | 46 | 125 grs. | do. | — | do. |
| 22 | D.F. | 3¹⁰/₁₂ | 31 | 35 grs. | do. | — | do. |
| 23 | N.S. | ¹¹/₁₂ | 18 | 30 grs. | do. | — | do. |
| 24 | K.W. | 1½ | 22 | 40 grs. | do. | — | 44 |
| 25 | E.H. | 2 | 26½ | 60 grs. | do. | — | 18 |
| 26 | D.T. | ⁵/₁₂ | 11 | 20 grs. | do. | — | 24 |

(*a*) Dosage quoted refers to aspirin only except in Case 5 where it refers to methyl salicylate and Case 26 where it refers to sodium salicylate.

(*b*) Case recovered.

TABLE II. INFANTS 2 YEARS OR UNDER WITH TOXIC EFFECTS FROM SALICYLATE ADMINISTERED THERAPEUTICALLY

| *No.* | *Name* | *Age (months)* | *Weight (lb.)* | *Original Disease* | *Mode of Administration (a)* | *Total Dosage (grains)* | *Period over which taken* | *Symptoms* | *Onset after 1st dose ± (hours)* | *Salicyl level (mg.%)* | *Result (b)* |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | J.P.W. | 8 | 12½ | 'Teething', fever and irritability for 2 days. Poor nutritional state | Asp./sulpha. mixt. 2½ grs.×7 | 17½ | 16 hrs. | Poor urinary output, hyperventilation. Later hyperpyrexia to 107°. Terminal convulsions | 20 | 33 | Died 48 hours. |
| 2 | W.D. | 12 | 23 | Coryza of 5 days' duration. Fever and anorexia | Sod. sal./sulpha. mixt. 2 gr. t.i.d. Asp. gr. 5 in addition | 35 | 5 days | Poor urinary output, hyperventilation for 12 hrs. Excitable. Later hyperpyrexia 106° and convulsions | 108 | Not done | Died 20 hours. |
| 3 | N.R. | 3 | 11 | Coryza and fever for 4 days. Anorexia. Poor urinary output | Asp. gr. 5 on 1st, 3rd and 4th day | 15 | 4 days | Persistent vomiting, hyperventilation, dehydration and convulsions | 96 | 40 | Died 15 hours. |
| 4 | N.R. | 7 | 16 | Pharyngitis and otitis for 1 week. Anorexia. Poor urinary output | Asp./sulpha. mixt. gr. 2, 4-hourly | 30 | 2½ days | Restlessness, pallor, dehydration, hyperventilation, hyperpyrexia to 106°, with terminal convulsions | 12 | 34 | Died 8 hours. |
| 5 | M.G. | 2 | 11 | Coryza and anorexia for 4 days | Asp./sulpha mixt. 2½ gr. 4-hourly. Mother gave extra 7½ grs. | 50 | 3 days | Pallor, dehydration, hyperventilation, terminal convulsions | 48 | Not done | Died 3 hours. |
| 6 | S.V. | 8 | 14 | Pallor since birth. Vomiting and diarrhoea for 2 days. Malnutrition and anaemia | Asp./sulpha. mixt. 2½ gr. 5 times a day | 25 | 2 days | Pallor, restlessness, dehydration, hyperventilation, hyperpyrexia to 106°, terminal convulsions | 36 | 44 | Died 10 hours. |
| 7 | C.F. | 3 | 8 | Cough and poor appetite for 1 week | Dose (administered by mother) not known | Unknown | | Restlessness, mild dehydration, hyperventilation | Uncertain | 54 | Recovered. |
| 8 | L.H. | 2 | 12 | Coryza and cough. Fretfulness for 5 days. Poor urinary output | Asp./sulpha. mixt. 1½ gr. 4-hourly | 11½ | 36 hrs. | Restlessness, slight dehydration, hyperventilation | 15 | 46 | Recovered. |
| 9 | B.T. | 2 | 11 | Coryza, anorexia for 4 days | Asp./sulpha. mixt. 4 gr. 4-hourly | 60 | 60 hrs. | Pallor, restlessness, hyperventilation | 48 | Not done | Recovered. |
| 10 | M.N. | 9 | 16 | Diarrhoea and vomiting for 2 days | Repeated doses of Asp. (unknown amounts) | Unknown | | Hyperventilation, hyperpyrexia, 105° | Uncertain | 16 | Died 30 minutes. |
| 11 | C.S. | 18 | 30 | Fever, cough, anorexia for 6 days | Repeated doses of Asp. (unknown amounts) | Unknown | | Perspiration, hyperventilation, pyrexia 101° | Uncertain | 11·2 | Recovered. |
| 12 | F.S. | 7 | 14 | Vomiting and diarrhoea for 3 days | Asp. 2½ gr. (1 dose) then 1½ gr. t.i.d. | 10 | 2 days | Slight dehydration, hyperventilation, pyrexia 101°. | 48 | 27 | Recovered. |
| 13 | C.V. | 2 | 7 | Coryza and cough, diarrhoea, anorexia for 6 days | Asp. 1½ gr. t.i.d. | 27 | 6 days | Hyperventilation, dehydration | 144 | 11 | Recovered. |
| 14 | R.B. | 3 | 14 | Cough, diarrhoea for 5-6 days | Asp./sulpha. mixt. 2½ grs. 4 times a day | 60 | 6 days | Hyperventilation. Pyrexia 104° | 160 | 57 | Recovered. |
| 15 | J.L. | 24 | 25 | Accidentally took 105 grs. aspirin. Vomited profusely, then given extra aspirin | Asp. gr. 105 (1 dose), then asp./sulpha. mixt. 3 gr.×6 | 123 | 24 hrs. | Refused fluids, vomiting, hyperventilation, hyper-pyrexia 109°. Convulsions | 28 | 61 | Recovered. |

(*a*) Asp.—aspirin. Asp./sulpha.—aspirin and sulphadiazine mixture. Dosage quoted refers to aspirin only, except in Case 2, where it refers to total salicylate.

(*b*) Time stated refers to time of death after admission.

(case 11), 2½ gr. (case 15) and 2¾ gr. (case 19) per lb. body weight. Yet in other cases toxic signs did not develop after doses as large as or larger than those taken in these latter 2 cases. There is therefore no fixed parallelism between dosage and toxicity; nor, as will be seen presently, between blood salicyl level and toxicity.

The second group comprises cases of salicylism occurring in small infants in whom the drugs were administered by either the doctor or the mother to treat some illness, mostly of minor nature. As can be seen from Table II, 13 of the 15 infants were 1 year of age or under; the remaining 2 were 1½ and 2 years old. In 8 of the 15 cases the intoxication was caused by ingestion of the drug in a sulphonamide mixture which had been prescribed for 4-hourly administration; in the remainder, aspirin had been given by the mother. In 3 cases the exact amount of salicylate ingested was not known; but in those where the dose was known, the lowest total dose was just under 1 gr. per pound (cases 8, 12), the highest total dose was over 5 gr. per pound (case 9), and the usual dose administered 1½-3 gr. per pound. The one feature common to all these infants before the aspirin was given was that they were ill and had not been eating or drinking well; and many showed a poor urinary output as indicated by infrequent urination.

### RELATIONSHIP OF BLOOD SALICYL LEVEL TO TOXICITY

The correlation of toxic effects of salicylates with the plasma salicyl level has been attempted by several authors. Wegria and Smull [18] maintained that toxic symptoms were not marked unless the plasma level exceeded 50 mg.%. Jager and Alway [6] found that no serious toxic symptoms occurred under 40 mg.%, but that hyperventilation tended to occur above this level. Graham and Parker,[7] in an excellent study, tried to correlate the appearance of various toxic manifestations with the salicyl level and found that vomiting tended to occur between levels of 16·3 and 38·6 mg.%; hyperventilation between levels of 21 and 44·2 mg.%; and severe dyspnoea between levels of 46 and 53·6 mg.%.

This would appear to indicate that the level at which toxic symptoms are manifested varies considerably in different individuals. Certainly in the series of cases presented here it is quite obvious that the serum salicyl level is by no means the only deciding factor. In the group of older children who ingested a single large dose of salicylate, the salicyl levels were not obtained in all cases, but in those where estimations were done, levels as high as 44 and 52 mg.% were found to be present in the absence of any symptoms whatever. In the group showing intoxication, very variable levels were obtained, from 11 to 61 mg.%.

Several contributing factors appear to determine the onset of toxicity. Symptoms of overdosage seem to be more common in small infants than in older children. All these infants revealed in their history some condition which diminished urinary output, e.g. anorexia, vomiting or diarrhoea. The children in the group who had received a single large dose were healthy and symptoms were usually absent. It is quite possible that diminished urinary output with poor excretion of the drug has a role in producing toxicity. This alone is not the only consideration and it certainly does not explain the wide range of salicyl levels at which toxic symptoms appear.

We suggest that there is an individual sensitivity to the drug and that, whatever the cause of hyperventilation, the respiratory mechanism responds at different salicyl levels in different individuals. There is probably greater sensitivity in infants than in older children, and sick persons may show a lower threshold than healthy individuals. The manner of ingestion may also be of some importance in deciding this problem. Most of the infants manifesting toxicity had received repeated doses of the drug, whereas the cases without toxicity had received a single large dose, and had reached a high salicylate level which fell rapidly owing to adequate urinary excretion. In the other group, however, repeated doses in the presence of poor urinary output resulted in cumulative effect.

The role of concomitant sulphonamide administration is not quite clear; certainly 8 of the cases with toxic manifestations had received this drug. Possibly it may further prejudice the urinary excretion of salicylate.

### SYMPTOMS AND DIAGNOSIS

*Symptoms of Toxicity.* The most important presenting clinical features in these cases were hyperventilation and restlessness. The respirations were deep, rapid and hissing, at a rate of 40 to 60 per minute. Dehydration was commonly present but not in an advanced degree, and chest signs were uniformly absent. Symptoms of toxicity were manifest as early as 12 hours and as late as 108 hours after the first dose. The infants had been referred to hospital for admission with diagnoses of acidosis, bronchopneumonia or encephalitis.

In all cases the urine showed a deep purple reaction on the addition of ferric chloride; and the colour did not disappear on boiling the urine, distinguishing the salicylate from the diacetic-acid reaction. Acetonuria was also present and the urinary reaction was strongly acid in all cases. Pyrexia occurred in 8 cases and in 6 of these a hyperpyrexia of 105° F or more was present; all but one of these 6 cases proved fatal. The prothrombin level was markedly reduced in all but one case; in several of the fatal cases purpuric eruptions appeared.

*Diagnosis*

The recognition of salicylate intoxication may be difficult. In the presence of a history of salicylate ingestion and typical signs and symptoms, the diagnosis is not usually in any great doubt. All too frequently, however, the information is not volunteered by the mother, since aspirin is generally regarded as completely innocuous. Unless the specific question of salicylate administration is asked, the matter may not be mentioned. In many of our cases salicylate was administered in a mixture by the practitioner and only after the diagnosis had been suspected was the presence of salicylate in the mixture confirmed.

Another important consideration is that salicylates are so universally used in the treatment of symptoms

that the mere history of ingestion or the presence of a salicylate reaction in the urine is not sufficient to establish the diagnosis of salicylate intoxication. Further, the clinical picture may be coloured by the symptoms of the underlying disease for which the salicylate was in the first instance prescribed. Even the salicyl level in the blood may not be helpful, although a high level is significant, for it is recognized that the level at which toxic effects may occur is variable. In an attempt to evaluate the significance of the salicyl level, we administered a single dose of 3 or 5 gr. of aspirin to each of 8 healthy infants under one year of age and determined the salicyl levels 3 to 5 hours later. The levels varied from 10·4 to 26 mg.%, so that, although the levels were all in the lower range, they were yet within the range where toxic symptoms sometimes occur; in none of these infants was toxicity noted. The drug is fully excreted within 24-36 hours.

The most important feature of salicylism is hyperventilation, and it is from other conditions which engender hyperventilation that salicylism is to be differentiated. The diagnoses most commonly suspected are pneumonia, encephalitis and acidosis. The main features differentiating salicylism and pulmonary disease are the absence of cough and cyanosis; the respirations in salicylism are deep and hissing, yet not laboured, and auscultatory signs are absent; the lungs on X-ray are clear. Encephalitis may be very difficult to exclude, since all the symptoms of salicylism may be produced by this disease. We performed lumbar puncture as a routine to exclude this condition. Acidosis with secondary hyperventilation may also be difficult to exclude. However, most cases of acidosis in infancy follow on diarrhoea of severe nature and usually the patient is moderately to markedly dehydrated. Rarely, other causes of acidosis, e.g. renal disease, require consideration.

Laboratory procedures may be of diagnostic assistance. (1) The salicyl level in the plasma and the salicyl urinary reaction are helpful but, if positive, do not necessarily exclude other diseases, since aspirin may have been administered therapeutically; a high salicyl level is, however, significant. (2) The $CO_2$-combining power is lowered in all these conditions and it is, therefore, of qualified value in differentiation. (3) The urinary pH and blood pH have their place both in diagnosis and treatment. In hyperventilation due to encephalitis or pulmonary disease there is usually an alkalosis, whereas in diarrhoeal disturbances with hyperventilation acidosis is present; salicylism produces an alkalosis in the initial phase, which is soon followed by ketosis and acidosis. (In none of our cases was the phase of alkalosis encountered, all having acidosis and ketosis.) (4) The prothrombin time is usually lengthened in salicylism, but this is by no means specific, as hypoprothrombinaemia may occur in cases of severe diarrhoea and infection. In our cases the prothrombin index varied from 0 to 54%.

A careful appraisal of the history and clinical examination, together with the laboratory data, generally clarifies the problem. However, one may still be presented with the occasional case where it is difficult to assess the part played by administered salicylate in producing symptoms, as contrasted with the symptoms of the original disease.

*Prognosis*

In our series 7 infants died. None of the infants or children who ingested a single large dose was seriously affected, and all the deaths were in small infants who had received repeated doses of salicylate. Signs of bad prognostic significance were hyperpyrexia and convulsions, and only one child with a fever above 105° F survived.

The period of delay before treatment was instituted was also of great importance, and the earlier treatment was begun after symptoms were manifest, the better was the prognosis.

*Autopsy Findings*

Stevenson[19] maintained that the lesions of methyl salicylate poisoning were primarily vascular, with secondary degenerative changes in the parenchymatous organs. In the autopsy findings reported by Lipman *et al.*[3] Troll and Menter,[20] and others, the main features were haemorrhagic phenomena of the nature of subpericardial and subpleural haemorrhages, subaponeurotic haemorrhage in the skull, and degenerative changes in the parenchyma of the liver, heart and kidneys, with cerebral congestion and oedema.

Autopsies were performed in all but one of the 7 cases who succumbed in our series. Haemorrhagic phenomena were present in all 6 cases. Four of the 6 showed subarachnoid haemorrhage, localized in the frontal region in 3, and round the base of the cerebellum in one. Subpericardial and subpleural petechial haemorrhages were present in all cases. All showed marked subarachnoid congestion and cerebral oedema. Cloudy swelling of marked degree was noted in the liver, kidneys and heart.

These autopsy findings do not substantially differ from those of any severe septicaemia or toxaemia, and this had to be considered in determining the part played by salicylate in causing death. In 4 of the cases, however, blood cultures were negative, whilst in the other 2 the dosage was so excessive and the clinical picture so typical that they were regarded primarily as salicylate intoxication.

## TREATMENT

There is no specific antidote for salicylate. The treatment is symptomatic, involving both the elimination of the drug and the management of secondary metabolic changes. Once hyperpnoea has occurred, gastric lavage to remove any unabsorbed drug is no longer helpful.[3] Lipman *et al.* also state that if lavage is performed sodium bicarbonate should not be used, as it increases absorption. We did not lavage any of the group presenting with symptoms of intoxication, since they had received the drug in repeated small amounts and most of the salicylate had certainly been absorbed. Gastric lavage was, however, performed in all those cases where a single large dose had been ingested.

Salicylates are excreted principally by the kidneys, and a good urinary output is of prime importance in their elimination. In the cases with no evidence of toxic effects, no treatment was undertaken other than the maintenance of a good fluid intake by mouth.

In cases with toxicity, however, where it was considered essential to institute measures to eliminate the drug rapidly, intravenous fluids were administered without delay.

Another important consideration is the necessity for correcting the electrolyte disturbance resulting from salicylate intoxication. In our cases, the stage of alkalosis was not encountered, but if alkalosis is present, alkaline fluids should not be administered. In the acidotic state, alkaline solutions of the nature of lactate are indicated. In our experience the rapid venoclysis of ⅙-molar sodium r-lactate in the amounts generally advised on the basis of weight and degree of lowering of $CO_2$-combining power, may be dangerous. In several of the cases in which this was administered pulmonary oedema and, later, convulsions ensued. It is difficult to incriminate this therapy, since these symptoms may well be due to salicylate intoxication itself. However, we have the impression that the course and outcome are more favourable if this solution is not used. In later cases, we used Ringer lactate solution with 5% dextrose (supplying much smaller amounts of lactate than the sodium r-lactate in ⅙ molar concentration) in quantities of ½-⅔ of the total fluid volume required for a 24-hour period, followed by 5% dextrose in distilled water. The electrolytic pattern was slowly reconstituted either by further venoclysis or (usually) by subsequent oral administration after 36-48 hours. This conservative regime certainly seemed to be more efficacious than that involving attempts at rapid correction of the electrolyte imbalance.

Vitamin K was used as a routine measure in the intravenous drip in amounts of 15-20 mg. to diminish the hypoprothrombinaemic effect of salicylate. Any underlying infection was treated with penicillin. One case was treated by exchange transfusion and is recorded in more detail.

Y.T., aged 11 months, weight 17 lb., was perfectly well until 1 week before being seen (10 p.m., 19 November 1951). During this period she had been restless and irritable, cried a great deal, went off her food, but was not feverish; no catarrhal symptoms; bowels slightly loose, but no actual diarrhoea. She was assumed, probably correctly, to be teething. For the last 2 days before admission to hospital she had shown increasing restlessness and a tendency to vomit. She did not appear to be seriously ill until 4 hours before admission, when she was noted to be breathing deeply and rapidly, with worsening air hunger. The more restless the infant had become, the more the mother had plied her with aspirin, so that in a period of 3 days she had been given 'not less than 15 grains daily', the total amount being approximately 50-55 grains.

Examination revealed a reasonably well-nourished European infant, markedly distressed. Pale and greyish, with extreme hyperpnoea and tachypnoea. Temperature 102° F. No jaundice. No neck rigidity. Fontanelle normal. Mouth and pharynx dry. Pulse 160, regular, fair volume. Heart sounds closed. Lungs resonant, sounds vesicular, no adventitious sounds. The diagnosis of aspirin poisoning was made, and the condition of the infant regarded as critical. Exchange transfusion was chosen as the mode of treatment most likely to give results. Though this treatment was experimental, and not previously tried in the hospital, it was felt that the infant stood little chance of survival with routine treatment (see Table III).

On 20 November 1951 from 12.15 a.m. to 2.15 a.m. the exsanguination transfusion was performed, 1,500 c.c. of blood being used. During the course of the exchange the infant had several tetanic spasms, and 10% calcium gluconate solution was repeatedly introduced intravenously to a total of 10 c.c. Electrocardiographic tracings showed extreme tachycardia and a suggestion of increased amplitude of the T-waves. The infant continued to be markedly hyperpnoeic throughout the transfusion, the pulse rate remaining at 160 beats per min.

3.15 a.m.: Hypernoeic and restless, but colour improved. Pulse rate 180-200 beats per minute.

8 a.m.: Definitely improved. Hyperpnoea less marked. Infant more peaceful. Not cyanosed. Respiration rate 50 per minute.

3.00 p.m.: Deteriorated: dyspnoeic, restless, cyanotic with absent breath sounds over the whole of the left chest. X-rays showed a left-sided pneumothorax and atelectasis, presumably due to pricking of the trachea when withdrawing blood from the left jugular vein. The infant's distress was now regarded as more probably due to the pulmonary condition. Blood salicylate level at this stage was 25 mg.%. A slow intravenous drip of Ringer lactate was nevertheless started, followed by intravenous dextrose, 5% in water.

By the following day the blood chemistry had returned to normal. It was now obvious that the infant would survive, and that the remaining dyspnoea was due to pulmonary atelectasis and pneumothorax. The infant continued to improve slowly, the air was gradually absorbed and the lung expanded. She was discharged in good condition 16 days after admission.

Interesting features of the case were the quick improvement in the $CO_2$-combining power and the rapid reduction of the blood salicylate level. Tetany and electrocardiographic changes in the presence of normal calcium values were due to alkalinization from sodium citrate in the exchanged blood.

## DISCUSSION

Ingestion of single massive doses of salicylate seldom results in anything more than a rushed visit by the child to the casualty Department of a hospital, a stomach wash-out, observation for 48 hours for evidence of toxicity, and later a heightened appreciation by the mother of the folly of leaving medicines anywhere but in a locked cupboard. The main reasons for the com-

TABLE III. BLOOD CHEMISTRY IN RELATION TO EXCHANGE TRANSFUSION

| | | *Salicyl level mg.%* | *$CO_2$ combining power (c.c.%)* | *Urea mg. %* | *Cl* | *Ca* | *K* | *Na* | *Prothrombin* | *Hb* | *PCV* | *RBC (millions)* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Before | | 53 | 18 | 34 | 695 | 10·4 | 19·6 | 367 | 79% | 7·9 | 31% | 5·0 |
| During: | After 600 c.c. | 40 | | | | | | | | | | |
| | After 1,500 c.c. | 28 | | | | | | | | | | |
| After: | 1½ hrs. | 34 | 28 | | | 12·6 | | | | 18·4 | 53% | 6·1 |
| | 8 hrs. | 25 | 38 | 56 | 740 | 8·0 | | | 85% | | 44% | |
| | 32 hrs. | 11 | 50 | | | | | | | | | |
| | 48 hrs. | <5 | 50 | 26 | | 10·0 | | | | | | |

parative innocuousness of accidentally-ingested salicylate would appear to be the good health and older age of the child, the usual rapidity with which the accident is detected and the stomach washed out, the vomiting of much of the drug, and rapid excretion by healthy kidneys.

On the other hand, the ingestion of repeated small doses is a matter of quite a different order, and salicylate intoxication has been encountered with disturbing frequency in small infants who received salicylate for therapeutic purpose. For the main part poisoning was consequent on the practice of administering aspirin and sulphonamide drug together in a mixture taken regularly every 4-6 hours. The potential toxicity of aspirin thus regularly administered is not appreciated. Often the salicylate is prescribed in an amount equal, or approximating, to that of the sulphonamide. The amount of salicylate given as a single dose is not excessive, but when repeated 4-hourly, it results in excessive accumulation. Ignorant of the fact that the mixture contained salicylate, in some of our cases the mother inflicted further damage on her child by attempting to allay restlessness by giving aspirin. Worse still, in the presence of a deteriorating picture, the mixture itself was sometimes given more often, with disastrous consequences.

This tendency of salicylate to pyramid within the body when given regularly over days is the spearhead of the danger. This is intensified when the child is out of sorts, when fluid intake is small and when urinary excretion is diminished; it is possible also, that tardy salicylate excretion may be linked with the co-administration of the sulphonamide in the mixture. Whilst it is not easy to assess the part played by the sulphonamide drug, it is significant that it was administered in 8 out of 15 cases in this group. Finally, having regard to the paucity of fatalities due to aspirin compared with the thousands of infants who receive this drug in comparable dosage, one cannot escape the belief that idiosyncrasy in terms of sensitivity of the respiratory centre may be a major factor.

The most informative symptom, which occurred in all our cases, was hyperventilation. This should always raise the suspicion of salicylism, particularly if the lungs are clear on physical examination and on X-ray. Many cases are diagnosed as pneumonia; the vomiting, restlessness, hyperpnoea, confusion, pyrexia and subsequent delirium and convulsions may suggest encephalitis; 'diarrhoea with acidosis' was the admitting diagnosis in other cases. Laboratory assistance in diagnosis was obtained by estimations of the blood salicylate level, the $CO_2$-combining power and the prothrombin index.

Where the initial illness was of minor nature it was not difficult to recognize salicylate intoxication. When the disease for which the sulphonamide-aspirin mixture was given was diarrhoea or a respiratory illness it became more difficult to apportion the symptoms as between illness and salicylate. The same reservation applied to some of the fatal cases, and it is doubtless this consideration which accounts for the scarcity of reports of salicylate intoxication in the literature, when the drug has been given therapeutically. However, there is recent evidence that this position is changing.[21, 22]

The aim in treatment is to promote diuresis and correct electrolyte imbalance. To this end, intravenous therapy is mandatory. We have found it unsafe to use alkalies, and prefer an infusion of Ringer lactate followed by 5% dextrose-water solution.

Exchange transfusion may have its place in treatment. In our one case an adequate exchange of probably 90% brought the salicylate level only from 53 mg.% to 28 mg.%; equilibrium was no doubt being maintained between blood and tissue levels, so that much salicylate was still out of the blood stream. It is possible that an even larger wash-out may be necessary, leaving a lower concentration in blood and tissues.

The authors are still convinced that aspirin is one of the most useful drugs in the therapeutic armamentarium of the paediatrician. Difficulties will be avoided if the dosage is carefully regulated and if practitioners are aware of the significance of persistent vomiting and, particularly, hyperventilation.

## SUMMARY

(1) Two groups of cases which received salicylate are presented. The first group of 26 cases accidentally ingested a single large dose, with 3 resultant cases of toxicity but no deaths. The second group comprised 15 infants who developed salicylate intoxication from

TABLE IV. SALICYLATE INTOXICATION: ADMISSIONS AND MORTALITY

(1952 TO END AUGUST 1954)

| Year | *Massive Ingestion* | | | *Therapeutic Administration* | | |
|---|---|---|---|---|---|---|
| | *Total No. of cases* | *Number of cases under 1 year of age* | *Deaths* | *Total No. of cases* | *Number of cases under 1 year of age* | *Deaths* |
| 1952 .. .. .. .. | 17 | 0 | 0 | 9 [1] | 7 | 1 [2] |
| 1953 .. .. .. .. | 15 | 1 | 1 [3] | 14 [4] | 11 | 3 [5] |
| 1954 (to end August) .. | 10 | 0 | 0 | 1 | 0 | 0 |

1. All 9 cases received a salicylate-sulphonamide mixture.
2. Infant of 8 months; died within a few minutes of admission.
3. From methyl salicylate.
4. Eight of these 14 cases received a salicylate-sulphonamide mixture.
5. All deaths in infants under 1 year of age. One infant died during an exchange transfusion; another at post mortem showed polycystic kidneys.

repeated 4-6 hourly doses therapeutically administered, 8 in the form of aspirin-sulphonamide mixture. In this group 7 infants died, to 5 of whom such a mixture had been given therapeutically.

(2) Salicyl level in the blood is not the only factor concerned in the development of toxicity. The age factor, dystrophy, the nature of the underlying disease and the role of oliguria are all considered. The part played by sulphonamide may be significant. It is postulated that sensitivity of the respiratory centre to salicylate may be a major factor responsible for the picture.

(3) The successful use in one case of exchange transfusion is reported.

### ADDENDUM

Since this paper was compiled there has been no appreciable alteration in admissions for massive ingestion. However, during 1954 to date there has been a significant reduction in the number of admissions for intoxication following therapeutic administration. Evidently the danger inherent in giving repeated regular doses of aspirin to infants under one year of age has gradually become known. The figures are set out in Table IV.

We wish to thank the Government Medico-Legal Laboratories, Johannesburg, for access to the autopsy findings, and our colleagues on the medical staff of the Transvaal Memorial Hospital for Children, Johannesburg, for permission to use their clinical material for publication. We also wish to thank Mr. Barnes of the South African Institute for Medical Research for his assistance and advice with the biochemical studies.

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# THE PRACTICAL IMPORTANCE OF BASAL TEMPERATURE GRAPHS FOR THE DIAGNOSIS OF PREGNANCY

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The usefulness of basal temperature graphs has been a subject for discussion since 1944. Tompkins, [1, 2] Davis,[3] Halbrecht,[4] Barton and Wiesner [5] have discussed this subject from every point of view. The original high hopes that the day of ovulation could be read with certainty have not materialized, and the controversy whether the drop in temperature, or the low point, or the elevation, indicates ovulation, has not been settled yet.

For practical purposes it is accepted that the waking oral temperature taken at the same time every morning in non-pregnant fecund women shows a characteristic diphasic pattern. The temperature taken from the end of the period remains at a relatively low level for several days and falls to a minimum during the mid-menstrual phase. It then becomes elevated and stays at a relatively high level until the end of the cycle. Four distinctive variations are more or less common:

LT—low-temperature phase (menstrual and mid-menstrual),

LH—shift from low to high (thermal shift),

HT—high-temperature phase (pre-menstrual),

HL—shift from high to low (menstrual fall).

The explanation as given by Davis [3] is that 'the activity of the corpus luteum in some way maintains the elevated post-ovulatory level'.

In pregnancy an important deviation from this diphasic rhythm occurs. The HT level is maintained or exceeded with slight fluctuations for a long time during gestation. If at the time of expected menstruation the temperature remains elevated to 99° F or above, persisting for more than 16 days, there is a strong likelihood of pregnancy. The question of this temperature elevation has been disputed and some, like Barton and Wiesner,[5] Grant [6] and Palmer [7] expect a level of 98·8—98·9° F to be suggestive of pregnancy. Certainly slight fluctuations of about 0·4° F in either direction are very common. According to my own findings a pregnancy test should not be carried out if the HT level is below 98·2° F, even if sustained for more than 16 days. If the pregnancy test has given a negative result with a consistently high HT level maintained

for more than 16 successive days, repetition of the test will very likely lead to a positive result. If a sudden fall occurs in a HT level which has been maintained for at least 16 days, a threatened abortion is to be expected.

In a previous paper[9] I pointed out the importance of this temperature elevation without being able at the time to clarify the position by practical demonstration. In the meantime Siegler *et al.*[8] have published a very conclusive summary showing the value of basal temperature charts. They arrived at the following important conclusions:

'1. Basal body temperature is of a definite but very limited value in infertility studies.

'2. It is not an accurate indicator of the time of ovulation.

'3. From the data submitted it appears that conception occurred with a greater facility in women in our series who had a "staircase" thermal shift than in those with "rapid" rise. The cause for this phenomenon cannot be explained.

'4. A distinct variability occurs in the length of the luteal phase. This variability does not seem to be a quantitative or a qualitative indicator of corpus-luteum activity.

'5. Basal body temperature is of proven value in the diagnosis of pregnancy in patients who maintain daily records. It is equally as accurate as the pregnancy tests commonly used and is less expensive. The cause of the temperature-drop to the low phase at about the 4th month of gestation is still a subject for speculation.

'6. Basal body temperature permits the evaluation of the efficacy of glandular, X-ray, and surgical therapy in gonadal dysfunction.

'7. In considering physiologic and biologic variability with regard to fertilization, the time of ovulation and the criteria for its recognition are important factors in evaluating the merits of any particular method. Basal body temperature interpretations of the time of ovulation require both an imagination and a rare diagnostic acumen for an unquestionable verdict.'

Two practical conclusions can be drawn from the above-mentioned authoritative statements:

1. Conception appears to occur with a greater facility in women with a 'staircase' thermal shift, than in those with a 'rapid' shift.

2. Basal body temperature is as accurate in the diagnosis of pregnancy as the pregnancy tests commonly used.

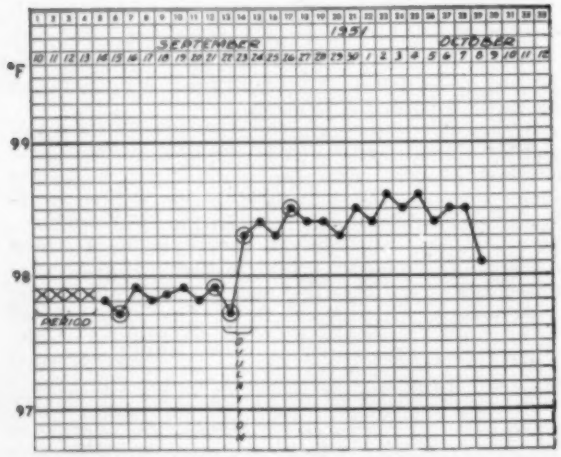
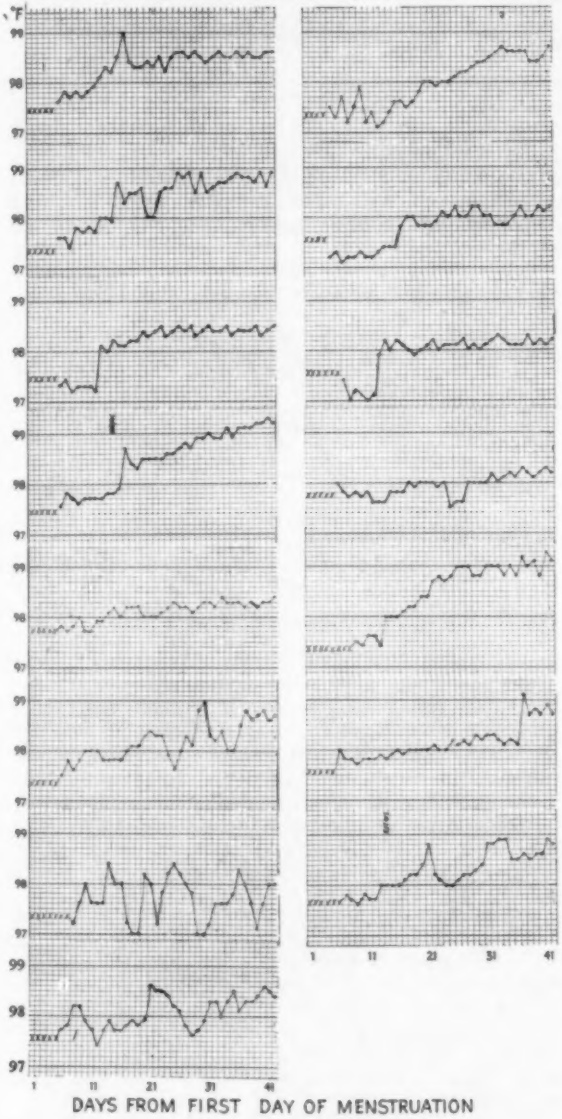



*Fig. A.*

Lane-Roberts[10] gives a very useful interpretation of the normal variations of waking temperature records; I therefore restrict myself to publishing one chart, which can be taken as an average normal record (Fig. A).

Fifteen cases of infertility in which basal temperature charts have been indicative of pregnancy and in which a positive Xenopus test confirmed the diagnosis of pregnancy may show the practical importance of these graphs. It should be possible to establish a diagnosis of pregnancy with almost 100% infallibility, often before the Xenopus test gives a definite positive result,




*Figs.* 1, 3, 5, 7, 9, 11, 13, 15 (left, from above downwards).
*Figs.* 2, 4, 6, 8, 10, 12, 14 (right, from above downwards).

if these charts are recorded with care by the patient. The shortest time for a Xenopus test to be reliable (96-98%) is about 2 weeks after the missed period, i.e. 42-46 days from the first day of the last period. In contrast, the luteal phase sustained for longer than 16 days at a level above 98·2° F is suggestive, and above the level of 99° F is conclusive, of pregnancy. As the beginning of the luteal phase is assumed to be about 14 days before the first day of the expected menstruation—in a menstrual cycle of 28 days, on the 14th day of the cycle—this reading would be confirmative on the 30th or 31st day from the beginning of the last menstruation.

*Case* 1 (A.E., Fig. 1) shows a sustained luteal phase for 42 days at the level of 98.6° F.

*Case* 2 (B.C., Fig. 2) shows a sustained luteal phase at the level of 98·6° F and on the 39th day a drop to 98·4° F. On this day the patient began to bleed but carried her pregnancy to term, using the normal precautions. The 'staircase' thermal shift may be observed in this case.

*Case* 3 (I.D., Fig. 3). This chart shows elevations with certain fluctuations to a level of 98·9° F and again the 'staircase' thermal shift.

*Case* 4 (M.P., Fig. 4) shows only an elevation to 98·2° F illustrating that normality in basal temperature charts is extremely variable.

*Case* 5 (C.A., Fig. 5) shows a rise of a sustained luteal phase to 98·5° F.

*Case* 6 (J.P., Fig. 6). Again temperature elevation to 98·3° F.

*Case* 7 (M.T., Fig. 7) shows the sudden rise after air insufflation performed on the 15th day of the cycle and an elevation to 99·3° F.

*Case* 8 (J.M., Fig. 8) shows a very inconsistent rise of the luteal phase to 98·2° F. This case aborted one month later.

*Case* 9 (L.B., Fig. 9). Temperature elevation to 98·3° F. Pregnancy proceeded uneventfully to term.

*Case* 10 (G.M., Fig. 10) is a very typical picture of a 'staircase' thermal shift pattern, showing a sustained luteal phase rising to 99·3° F.

*Case* 11 (A.W., Fig. 11) shows a very irregular pattern and temperature elevation up to 99° F.

*Case* 12 (E.C., Fig. 12). This case was very irregular in its picture, yet this irregular picture demonstrated a pregnancy and was confirmed by Xenopus test.

*Case* 13 (H.S., Fig. 13) shows a very slow 'staircase' thermal shift and a rise in temperature up to 99·1° F and ended in an abortion after 3 months.

*Case* 14 (N.V., Fig. 14) shows again a pregnancy occurring after air-insufflation on the 14th day of the cycle and an elevation up to 98·9° F.

*Case* 15 (D.W., Fig. 15) shows an irregular picture with a temperature elevation to 98·6° F.

*In conclusion* from the literature and the 15 cases and graphs shown it appears:

1. That with pregnancy the maintained luteal level over 16 days may be lower than 98·8° F,

2. That a sudden fall in temperature after 16 days sustained luteal phase may be indicative of a threatened abortion.[3, 4, 5]

My experience also leads me to the conclusion that the lower the temperature of the sustained luteal phase, the more an abortion is likely to occur at a later date (see case 8).


## SUMMARY

It is demonstrated on 15 cases:

1. That a sustained luteal phase for longer than 16 days at a level above 98·2° F is suggestive of pregnancy.

2. The continuance of the sustained luteal phase for longer than 16 days at a level of 99° F is conclusive of pregnancy.

3. The basal temperature graph, if carefully recorded by the patient, allows the diagnosis of pregnancy on the 31st day from beginning of the last menstruation, in contrast to the Xenopus test which needs 42-46 days from the same day.

4. A drop of 0·3—0·4° F in the sustained luteal phase is suggestive of a threatened abortion.[3, 5]

5. A pregnancy test should not be carried out if the HT level is below 98·2° F.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# FEDERAL COUNCIL OF THE MEDICAL ASSOCIATION OF SOUTH AFRICA

## MINUTES OF MEETING HELD AT PRETORIA ON 28, 29 AND 30 OCTOBER 1954

Following are the minutes of a meeting of the Federal Council of the Medical Association of South Africa, held in the Hotel Assembly, Pretoria, on 28, 29 and 30 October 1954.

*Present:*

*Ex Officio:* Dr. J. H. Harvey Pirie (Immediate Past Chairman), Dr. J. S. du Toit (Honorary Treasurer).

*Border Branch:* Dr. L. L. Alexander, Dr. R. Schaffer.

*Cape Eastern Branch*: Dr. L. R. L. Solomon.

*Cape Midlands Branch:* Dr. L. E. Lane, Dr. M. A. Robertson.

*Cape Western Branch:* Mr. J. A. Currie, Dr. F. O. Fehrsen, Dr. A. I. Goldberg, Dr. A. Landau, Dr. J. R. E. Lee, Mr. T. B. McMurray, Mr. J. A. S. Marr, Dr. F. W. F. Purcell, Mr. M. Cole Rous, Dr. A. W. S. Sichel.

*East Rand Branch:* Dr. J. Q. Ochse, Dr. M. Segal. Dr. E. W. Turton.

*Griqualand West Branch:* Dr. J. P. Collins.

*Natal Coastal Branch:* Dr. A. Broomberg, Dr. E. W. S. Deale, Dr. H. Grant-Whyte, Dr. A. B. Taylor.

*Natal Inland Branch:* Mr. B. A. Armitage, Dr. A. L. Young.

*Northern Transvaal Branch:* Dr. J. G. A. du Toit, Dr. J. H. Struthers, Dr. J. H. Sypkens, Dr. W. Waks, Dr. F. Ziady.

*O.F.S. and Basutoland Branch:* Dr. D. Serfontein, Dr. R. Theron, Dr. G. F. C. Troskie, Dr. J. S. Visser.

*Southern Transvaal Branch:* Dr. C. Adler, Dr. A. L. Agranat, Dr. J. Black, Dr. W. Chapman, Mr. G. T. du Toit, Dr. S. C. Heymann, Dr. M. Peskin, Dr. T. Radloff, Dr. L. S. Robertson, Dr. T. Schneider, Dr. M. Shapiro, Dr. L. O. Vercueil, Mr. J. Wolfowitz.

*South-West Africa Branch:* Dr. J. P. S. McConnell.

*Transkei Branch:* Dr. I. Ross.

*In Attendance:* Dr. A. H. Tonkin (Secretary), Dr. L. M. Marchand (Associate Secretary).

*Observer:* Dr. T. Shadick Higgins (Editor).

## THURSDAY, 28 OCTOBER

The meeting commenced at 10.10 a.m.

1. *Election of Temporary Chairman:* The Secretary, Dr. Tonkin, called for nominations for the post of temporary Chairman of the meeting.

Dr. Vercueil proposed Dr. Sichel and was seconded by Dr. Sypkens. There were no other nominations and Dr. Sichel was asked to accept this temporary post. He then took the Chair.

2. *Notice Convening the Meeting*, which had been published in the *Journal* of 18 September 1954, was taken as read.

3. *Proxies and Apologies:* The Secretary announced Proxies as follows: Dr. J. S. du Toit to act for Dr. R. Lance Impey; Mr. J. A. Currie to act for Dr. J. P. de Villiers; Mr. J. Wolfowitz to act for Dr. J. Gluckman. It was noted that Dr. J. P. S. McConnell held Dr. H. C. Paradisgarten's proxy only in respect of the Annual General Meeting. The Chairman stated that in the circumstances Dr. McConnell, although he could remain at the meeting, could not take part in the proceedings. He suggested that a telegram be sent to Dr. Paradisgarten, pointing out that he had omitted to give Dr. McConnell the necessary authority and asking him to telegraph his proxy to the Secretary. *Council agreed* to this procedure.

Apologies were received from Dr. R. Lance Impey and Dr. N. A. Rossiter.

4. *Introduction of New Members:* The Chairman asked that new members be introduced. Dr. Theron introduced Dr. G. F. C. Troskie and Dr. J. S. Visser; Dr. Vercueil introduced Drs. C. Adler, T. Radloff and A. Agranat and Mr. G. T. du Toit; Dr. Broomberg introduced Dr. E. W. S. Deale; Dr. Ochse introduced Drs. E. W. Turton and M. Segal; Dr. Lane introduced Dr. M. A. Robertson; Dr. Struthers introduced Drs. F. Ziady and J. G. A. du Toit; Dr. J. S. du Toit introduced Drs. F. W. F. Purcell and J. R. E. Lee and Messrs. T. B. McMurray and J. A. S. Marr; Mr. Currie introduced Dr. F. O. Fehrsen.

5. *Election of Chairman of Council:* The Chairman called for nominations. It was proposed by Dr. Vercueil, seconded by Dr. Waks, that Dr. Sichel be elected Chairman of Council. There were no other nominations and Dr. Sichel was *unanimously* elected, amid *acclamation.*

The President invested Dr. Sichel with the badge of office of Chairman of Council.

In reply, Dr. Sichel said that although his inclination had been to seek more leisure, he would be willing to continue as Chairman of Council if members felt that it was in the interests of the Association. He thanked the Council not only for the honour but for the confidence which they had shown in him in asking him to resume the Chair, and said that he would do his best to serve the interests of the Association in the coming three years. *Acclamation.*

6. *Election of Vice-Chairman of Council:* Nominations were called for and Mr. Currie proposed Dr. Struthers, being seconded by Dr. Grant-Whyte. Dr. Peskin proposed Dr. M. Shapiro, but Dr. Shapiro declined to accept nomination. There were no other nominations and Dr. Struthers was declared elected, amid *acclamation.*

7. *Election of Vice-President/President-Elect:* The Chairman called for nominations, and Dr. Waks proposed Dr. Struthers, being seconded by Dr. Sypkens. Dr. Troskie proposed Dr. Serfontein, who declined to accept nomination. There were no other nominations and Dr. Struthers was declared *elected*, amid *acclamation.* He thanked the Council for the high honour bestowed on him.

8. *Appointment of Honorary Treasurer:* The Chairman called for nominations, and Mr. Armitage proposed Dr. J. S. du Toit. He expressed appreciation of the hard work done by Dr. du Toit for so many years.

There were no other nominations and Dr. du Toit was declared *appointed, amid acclamation.* He expressed appreciation of the confidence shown in him.

9. *Appointment of Secretary of Council:* The Chairman called for nominations, and Dr. Shapiro proposed Dr. Tonkin, being seconded by Dr. Peskin. There were no other nominations and Dr. Tonkin was declared *appointed, amid acclamation.*

### ELECTION OF COMMITTEES OF COUNCIL

10. *Executive Committee:* The Secretary read the relevant By-Law and announced the names of the members of the old Committee. He stated that the *ex officio* members of the new Committee would be Drs. Sichel, Struthers, Harvey Pirie, Lane and du Toit, and that it would be necessary to elect five members to complete the Committee, not more than three of the whole Committee to represent any one Branch.

Dr. Vercueil proposed Drs. Shapiro and Heymann; Mr. Armitage proposed Dr. Grant-Whyte; Dr. Alexander proposed Dr. Schaffer; Dr. Struthers proposed Dr. Waks, but Dr. Waks declined; Dr. Lane proposed Dr. Theron; Mr. McMurray proposed Mr. Cole Rous; Dr. Black proposed Dr. L. S. Robertson; Dr. Ochse proposed Dr. Turton. A ballot vote was taken, Mr. McMurray being appointed to act as scrutineer with the Secretary.

While the ballot was being counted, the Chairman made various announcements regarding the Adjourned General Meeting and certain social functions which had been arranged by the Northern Transvaal Branch.

The result of the ballot was then announced, the elected members of the Executive Committee being Mr. Cole Rous, Dr. Schaffer, Dr. Shapiro, Dr. Theron and Dr. Grant-Whyte. They were declared *elected amid acclamation.*

11. *Federal Ethical Committee:* The Secretary mentioned the names of the members who had formed the old Committee, and the Chairman asked Council to nominate five members to this Committee.

Dr. Grant-Whyte proposed Dr. Broomberg; Dr. L. S. Robertson proposed Dr. Schneider; Dr. Shapiro proposed Dr. Goldberg; Mr. Currie proposed Dr. Purcell; Mr. Wolfowitz proposed Dr. Sypkens; Dr. Heyman proposed Dr. Collins, but Dr. Collins asked permission to withdraw. There were no other nominations, and in the circumstances the remaining five nominees were declared *elected, amid acclamation.*

12. *Central Committee for Contract Practice:* The Secretary announced the names of the members who had formed the old Committee.

Discussion took place as to how the new Committee should be constituted. Eventually it was proposed by Dr. Vercueil, seconded by Mr. Currie and *resolved* that the Central Committee for Contract Practice consist of three members from the Southern Transvaal Branch, two members from the East Rand Branch, two members from the Northern Transvaal Branch and one member from most of the other Branches. On the proposal of the Chairman, it was further *agreed* that the members should have the right to appoint alternates to attend meetings of the Committee. The Chairman then called for nominations.

Mr. Armitage proposed Dr. Grant-Whyte for the Natal Coastal Branch, who declined and in turn proposed Dr. Broomberg; Dr. Schaffer proposed Dr. Alexander for the Border Branch; Dr. Broomberg proposed Mr. Armitage for the Natal Inland Branch; Dr. Sypkens proposed Drs. J. G. A. du Toit and Ziady for the Northern Transvaal Branch; Dr. Serfontein proposed Dr. Visser for the O.F.S. and Basutoland Branch; Dr. Turton proposed Drs. Segal and Ochse for the East Rand Branch; Mr. Wolfowitz proposed Drs. Vercueil and Peskin and Mr. G. T. du Toit for the Southern Transvaal Branch; Dr. Lane proposed Dr. M. A. Robertson for the Cape Midlands Branch; Dr. Purcell proposed Mr. Currie for the Cape Western Branch; Dr. Schneider proposed Dr. Agranat, and Dr. Grant-Whyte proposed Dr. Chapman, for the Southern Transvaal Branch; Dr. Waks proposed Dr. Collins for the Griqualand West Branch; Dr. Grant-Whyte proposed Dr. Serfontein for the O.F.S. and Basutoland Branch, but Dr. Serfontein declined to accept nomination. Dr. Schaffer proposed Dr. Paradisgarten for the South-West Africa Branch if he would agree to serve. Dr. Ross was asked whether it would be necessary to appoint a representative from the Transkei Branch, but he replied that he did not think that it would be necessary.

The Chairman stated that it would be necessary to hold a ballot in so far as the Southern Transvaal Branch representation was concerned, Drs. Marchand and Ziady being appointed scrutineers. The result of the ballot was then announced and Dr. Vercueil and Mr. G. T. du Toit were declared elected, there being a tie between Drs. Agranat and Chapman. The Chairman ruled that a further ballot be held, and as a result Dr. Chapman was declared elected.

13. *Parliamentary Committee:* The Chairman said that the Executive Committee had discussed the composition of the Par-

liamentary Committee, recognizing that it had been agreed at the last meeting of Council that the nucleus of the Committee should be in Pretoria. Dr. Struthers had been Chairman of the Committee.

Dr. Struthers stated that this arrangement had worked satisfactorily with liaison with the Secretary of the Association in Cape Town. He felt that the best way for the Committee to function would be to make it a Transvaal Committee and have the Secretary and the members of the Executive Committee resident in Cape Town to act as a Liaison Committee for any work which might have to be done in that city during the Parliamentary session. He thus proposed that the Parliamentary Committee, as a working committee, consist of the Federal Council members of the Northern Transvaal Branch, together with the Executive Committee members resident in the Transvaal. This was seconded by Dr. Broomberg and *carried*. The Parliamentary Committee thus consisted of Drs. Struthers, Waks, J. G. A. du Toit, Ziady and Sypkens, together with Drs. Harvey Pirie and M. Shapiro, while Drs. Sichel and J. S. du Toit, Mr. Cole Rous and the Secretary would form a Liaison Committee in Cape Town.

14. *Minutes* of the Meeting of Council held in Johannesburg on 29 and 30 April and 1 May 1954, were *confirmed and signed.*

MATTERS ARISING OUT OF THE MINUTES

15. *Administration of Anaesthetics by Registered Nurses and Registered Midwives:* The Secretary reported that the decision of the Council had been communicated to the Secretary for Health.

Dr. Struthers stated that this matter was referred to in the Report of the Liaison Committee with the S.A. Nursing Association. The decision of Council had apparently been conveyed to the S.A. Nursing Association by the Secretary for Health and they had taken exception to it. At a meeting of the Liaison Committee an attempt had been made to amplify the resolution of Council in a way which would be satisfactory to the nurses. The resolution taken at the last meeting had read:

'1. That under conditions of emergency it must be clear that it is the duty of a nurse to carry out any instructions, including the administration of anaesthetics, given by the doctor under his responsibility.
2. That Council does not approve of any formal training in anaesthesia for nurses, other than such as is at present given, viz. gas-air analgesia.'

These had been altered to read:

'1. That under conditions of emergency *and when no other doctor is available*, it must be clear that it is the duty of a nurse *or midwife* to carry out any *lawful* instructions, including the administration of anaesthetics, given by the doctor under his responsibility.
2. That Council does not approve of any formal training in anaesthesia for nurses *and midwives*, other than such as is at present given, viz. gas-air analgesia.'

Dr. Black said that he did not agree with the alterations which had been made, and he moved that the previous resolutions of Council be rescinded. This was seconded by Mr. Wolfowitz and, on being put to the vote, was *carried* by 19 votes to 17. Dr. Black then proposed, seconded by Dr. L. S. Robertson, that the original resolution be altered by the addition of the words 'and where no other doctor is available', and that the word 'lawful' be changed to 'reasonable'.

Dr. Shapiro, seconded by Dr. Struthers, moved an amendment that the original resolution of Council, as amended by the Committee, be reaffirmed. Debate ensued, and when the amendment was put to the vote it was *carried*. It was also *carried* as a substantive motion

16. *Attendance at Court Proceedings:* The Secretary reported that the memorandum submitted by the Northern Transvaal Branch had been referred to the Minister of Justice. A reply, dated 14 July, had been received from the Secretary for Justice and had subsequently been referred to all Branch Secretaries and published in the *Journal* for general information. *Noted.*

17. *Vanderbijlpark Medical Benefit Fund:* The Secretary reported briefly on this matter, and it was proposed by Dr. Schneider, seconded by Dr. Peskin, that consideration of the whole problem of the Vanderbijlpark Medical Benefit Fund be deferred to the next meeting of Council.

Drs. Vercueil and Chapman spoke against delay, and an amendment was proposed by Mr. Cole Rous, seconded by Dr. Grant-Whyte, that discussion regarding the Vanderbijlpark Medical Benefit Fund be postponed until a more suitable occasion. With the consent of his seconder, Dr. Schneider accepted Mr. Cole Rous's amendment, which was put to the vote and *carried nem. con.*

18. *Termination of Membership of Full-time Medical Officer:* The Secretary reported that the Executive Committee recommended that no action be taken at this stage but that the matter be considered at the next meeting of Council. He explained the circumstances, arising out of a recommendation to Council by the Southern Transvaal Branch.

Dr. Shapiro pointed out that acceptance of the recommendation of the Executive Committee would not mean condonation of the action which had been taken, but merely the postponement of a decision until the next meeting of Council. He moved that the recommendation of the Executive Committee be accepted by Council, and was seconded by Dr. Theron. On being put to the vote, this was *carried nem. con.*

19. *Pathological Services in the Transvaal:* Letters from the Minister of Health and the Registrar of the S.A. Medical and Dental Council were submitted, and Dr. Struthers proposed that these be noted, adding that the matter would have to be raised again in the Reports of the Parliamentary Committee and the Augmented Executive Committee for the Transvaal. He was seconded by Dr. Sypkens, and *Council agreed.*

20. *Articles in Medical Auxiliary Journals:* Correspondence with the Assistant Registrar of the S.A. Medical and Dental Council was submitted, and the Secretary stated that the Executive Committee recommended to Council that it be considered unethical for medical practitioners to contribute signed articles to journals run by unregistered medical auxiliaries, and that Secretaries of Groups be informed of this and be asked to inform their members. Dr. J. S. du Toit moved accordingly, seconded by Dr. Adler, and *Council agreed.*

21. *Income Tax Deductions in respect of Post-Graduate Study Expenses:* The Secretary submitted a memorandum containing the information which he had received from a number of member-Associations of the World Medical Association, and he reported that the Executive Committee recommended to Council that the World Medical Association be asked to conduct a survey on this subject throughout its member-Associations and that it also be asked to consider making a recommendation in this regard. Dr. Heymann moved that the recommendation of the Executive Committee be accepted, seconded by Dr. Theron, and *Council agreed.*

22. *Shortage of Nurses:* The Secretary referred to an article on this subject which had appeared in the *Journal*, and read a resolution from the Griqualand West Branch which had been received too late for inclusion in the Agenda for the last meeting of Council. The resolution read: 'On the basis of the suggestions made by Dr. Julius Kretzmar in his Valedictory Address to the Griqualand West Branch, Federal Council should go into ways and means of improving the position as regards the shortage of nurses.' The Secretary added that the Executive Committee recommended to Council that the article in the *Journal* be noted.

It was proposed by Dr. Shapiro, seconded by Dr. Struthers, that the recommendation of the Executive Committee be accepted.

Discussion followed and various speakers drew attention to the need for more nurses. An amendment was proposed by Dr. Peskin, seconded by Dr. Schneider, that the Minister of Health be asked to appoint a Commission to enquire into the shortage of nurses. After further discussion, the amendment was put to the vote and was *lost*.

The original proposal that the article in the *Journal* be noted was then put to the vote and *carried*.

Council adjourned for lunch from
1 p.m. to 2.20 p.m.

23. *Supplies of Drugs kept in Nursing Homes:* Dr. Black asked whether anything further had been done regarding this matter. The Secretary replied that there was no way of letting individual nursing homes know of the decision reached, but that the information had been published in the *Journal* for the benefit of members. *Noted.*

24. *British Medical Association Meeting, Glasgow, 1954:* The Secretary stated that the Association's representative, Mr. J. D. Joubert, had submitted a report on his visit. At the request of the Council, he read the report, which was *noted.*

25. *Financial Report by Honorary Treasurer:* Members were referred to the Report in the Annexures, which was amplified by

the Honorary Treasurer, Dr. J. S. du Toit. He explained why the expected surplus would exceed that which had been estimated and gave information regarding text and advertising pages in the *Journal*. He also referred to the Agencies and the losses sustained in Cape Town and Durban during the current year, put praised the good work being done by them. He spoke of the Association's favourable financial position and said that a substantial profit might be shown at the end of the year which would help to offset the losses which had been sustained during the past three years. He paid tribute to the work of the Head Office and *Journal* staff and said that he felt that the Head Office and *Journal* Committee would be justified, if the Council thought fit, to show some tangible acknowledgment of the services rendered by the staff.

The Report was *received with acclamation.*

Discussion followed which dealt mainly with the unfortunate financial position of some of the Branches, until the Chairman ruled that the financial position of the Branches should not be discussed at that time.

Dr. Shapiro then moved that the Treasurer be congratulated on the state of the finances of the Association. This was seconded by Dr. Vercueil, who said that he wished to express his appreciation of what the Chairman and the Head Office and Journal Committee had done in creating a buoyant state of affairs in regard to the Association's finances. *Carried.*

*Note:* At this stage, the Chairman announced that a telegram had been received from Dr. Paradisgarten empowering Dr. McConnell to act as his proxy at the meeting. *Noted.*

REPORT ON MATTERS DEALT WITH BY THE EXECUTIVE COMMITTEE

26. *Amendment of Constitution of National General Practitioners' Group:* Members were referred to the report in the Annexures which showed that this Group wished to establish a National Committee which would be constituted on much the same lines as the Federal Council. The Chairman stated that the members of the Executive Committee had differed in their opinions regarding the formation of this National Committee, and that the matter was now placed before the Council for decision. He pointed out that the question of the policy of the Group would be left in the hands of the Executive Committee of the Group and not the National Committee itself.

It was proposed by Dr. Shapiro, seconded by Dr. Broomberg, that the amendments to the Constitution of the General Practitioners' Group be accepted. After considerable discussion, Dr. Shapiro said that he would take the responsibility personally for putting to Federal Council an amendment, 'That the general control and direction of the policy and affairs of the Group shall be vested in the National Committee and its Executive Committee'.

It was proposed by Mr. Cole Rous, seconded by Dr. Broomberg and *resolved nem. con.* that Dr. Shapiro's assurance be accepted.

A vote was then taken on the question of approving the amendments to the Constitution as further amended by Council. This was *carried with one dissentient vote.*

27. *Medical Treatment for Colonial Service Pensioners:* A letter was submitted from the office of the High Commissioner for the Protectorates, in which a request was made that the Tariff of Fees for Approved Medical Aid Societies should apply to Colonial Service pensioners resident in the Union, whose pensions were paid through one of the High Commission Territories Administrations, on the same lines as the pensioners of the High Commission Territories were treated.

The Secretary reported that the Executive Committee recommended to Council that the proposal of the High Commissioner be accepted. *Council agreed.*

28. *Submission of Fee Schedules to S.A. Medical and Dental Council:* The Secretary reported that there had been some doubt as to whether the resolution passed at the previous meeting of Council had applied to Branches as well as Groups. The matter had been placed before the Executive Committee for clarification, and it had been ruled that the strictures would apply only to Groups.

*Council confirmed* the decision of the Executive Committee.

29. *Loan to College of Physicians and Surgeons of South Africa:* The Secretary stated that an application had been received from the Steering Committee of the College of Physicians and Surgeons of South Africa for the loan of £1,000, subject to interest at the rate of 5% per annum. The Executive Committee had agreed that such a loan be made.

*Council confirmed* the action of the Executive Committee.

30. *Resolutions from Congress:* The Secretary stated that in accordance with the new procedure, he had received resolutions which had been passed at the 39th South African Medical Congress held in Port Elizabeth in June, 1954. These had been submitted to the Executive Committee and read as follows:

*I. Resolution from Plenary Session of Congress:* 'That this 39th Medical Congress of the Medical Association of South Africa, having considered the wastage of man power, the suffering of humanity and the needless expense arising out of the many diverse fields of disablement, commends to the Government the urgency of establishing a National Rehabilitation Council. Amongst others, important functions of such a Council would be:

(*a*) To accept the offered co-operation of commerce and industry.

(*b*) To advise the Minister and existing voluntary bodies regarding a national rehabilitation policy, in respect of physically and mentally handicapped, to ensure unity of purpose.

(*c*) To advise on practical ways in which the efforts of both State and voluntary enterprise can be effectively correlated in conformity with the formulation of a national policy referred to in (*b*).

(*d*) To advise on gaps in the field of rehabilitation and on ways to bridge such gaps including executive action by the Council itself to provide the necessary services where these are lacking.

(*e*) To give attention with the appropriate health and hospital authorities to the health and medical aspects of rehabilitation, whether in the field of Union Government or Provincial Departments to encourage research and sociological service in various fields concerned with the problem of rehabilitation. To respect the autonomy of existing national voluntary bodies and Government Departments in this field.

(*f*) To advise the Minister concerned on legislation in the respective rehabilitation of handicapped persons, more particularly of comprehensive consolidating legislation.

(*g*) Finally we pledge the Association in offering technical assistance such as lies within its power in the planning and the working of such a Council'.

The Secretary stated that the Executive Committee had resolved that copies of this resolution be sent to the Ministers of Health, Social Welfare and Labour.

*II. Resolution passed by Hospital Administrators' Group at Congress:* 'This, the 39th South African Medical Congress, deplores the lack of accommodation for certifiable mental cases, often necessitating the detention of such patients in gaol. The Union Government is urged to provide adequate accommodation for mental cases as a matter of high priority, and, in order that the public general hospitals can be placed in a better position to assist the Department of Health in dealing with cases suitable for treatment in a general hospital, it is recommended that the Mental Disorders Act be amended and general hospitals be classed as institutions which may legally detain mentally disordered patients.'

The Secretary stated that the Executive Committee had resolved that copies of this resolution be forwarded to the Minister of Health, the Secretary for Health, the Commissioner for Mental Hygiene and the Directors of Hospital Services of the four Provinces.

*III. Resolutions from Public Health Section of Congress:*

(*a*) The Medical Officers of Health Group strongly suggest to the Association for future Congresses that the time of the Congress Photograph be such as not to interfere with the presenting of papers.

(*b*) That it be a recommendation to Federal Council that consideration be given to the advisability that some form of notification of Cancer be introduced.

(*c*) This 39th South African Medical Congress strongly urges the Honourable the Minister of Health to take the necessary steps to ensure that milk and its products be made increasingly available to the lower income population group by subsidy if necessary, in order to avoid malnutrition and thus save expenditure on Tuberculosis and other diseases resulting from malnutrition.

(*d*) This 39th South African Medical Congress wishes to direct the attention of the Union Government to the fact that the expectation of useful human life has greatly increased and in consequence recommends that the retirement of public servants at the age of 60 years is no longer in keeping with the modern outlook. To deprive the community of the services of able and experienced administrators is a retrograde policy and contrary to the public welfare.'

The Secretary stated that the Executive Committee had resolved

that Resolutions (*b*), (*c*) and (*d*) above be referred to the Minister of Health.

He then submitted replies which had been received and which indicated that Governmental co-operation could be expected.

*Council confirmed* the action taken by the Executive Committee.

31. *Mines Benefit Society:* Members were referred to a report which had been submitted, in which it was stated that the Executive Committee agreed that no action should be taken by the Association in regard to the question of the Confinement Fees paid to medical officers of the Society, and the full-time appointment at Blyvooruitzicht.

The Chairman reported that the Chairman of the Mines Benefit Society had met the Executive Committee on the previous day and that Council was now being asked to approve the action taken by the Executive Committee. *Council confirmed* the action taken by the Executive Committee.

32. *Appointment of Sub-Committee on the Economics of Medical Practice:* The Secretary stated that Notice of Motion had been given by Mr. Wolfowitz and Dr. Peskin, reading:

> 'That in the opinion of Federal Council the time has come to review the whole question of the provision of medical services to industry in general. To this end it should be resolved to take the initiative in calling a conference at the highest level, at which representatives of the Medical Association, leaders of industry and other interested parties can discuss the problems which arise when medical services are provided by contract to employees. That an *ad hoc* committee, assisted by legal and actuarial experts, be appointed to make preliminary enquiries as to the possibility of calling such a conference and, if necessary, to convene it. The necessity for the continuation of the Vigilance Committee will thus no longer exist.'

The proposer and seconder spoke in support of the resolution, as did other members. On being put to the vote, the resolution was *carried nem. con.*

The Chairman said that Council should determine the number to serve on the Committee and nominate the members. He felt that the members of the Committee should be resident in a centre where they could easily meet, and suggested that it be in the Transvaal. Council *agreed.* Council further *agreed* that the Committee should consist of eight members, and nominated Mr. Wolfowitz and Drs. Shapiro, Peskin, Vercueil, J. G. A. du Toit, Ochse, Ziady and Agranat to serve on the Committee; Dr. Shapiro to act as the Convener.

The Chairman suggested further that the Committee should meet and draw up terms of reference and go into the question of being allowed to employ secretarial assistance, and that its recommendation should be submitted to the Executive Committee for approval. *Council agreed.*

33. *Tariff of Fees for Medical Boards:* The Secretary read a resolution submitted by the Cape Western Branch, in which it was requested that there be an increase in the fees paid to doctors serving on medical boards. He stated that the Executive Committee recommended to Council that the matter be referred back to the Branch for more information as to the suggested fees and the reasons why they should be increased. *Council agreed.*

### FEDERAL ETHICAL COMMITTEE

34. *Publication of Booklet on Ethics:* The Secretary reported that the booklet entitled 'A Guide to the Maintenance of Ethical Standards' had been published and circulated to all members of the Association. He had brought to the notice of the Executive Committee the fact that the booklet had not been translated into Afrikaans, and the Executive Committee recommended to Council that the booklet be translated into Afrikaans forthwith and that it be printed and circulated to members. *Council agreed.*

### HEAD OFFICE AND JOURNAL COMMITTEE

The Vice-Chairman took the Chair, and Dr. Sichel, as Chairman of the Committee, presented the Report, which was considered seriatim:

35. *Meetings of the Committee* There had been six ordinary monthly meetings of the Committee since the last report to Council. One of these meetings had been continued a week later as an adjourned meeting. The average attendance had been eight members. Two members of the Committee had been on leave of absence overseas. *Noted.*

36. *Minutes of Committee Meetings* Since the last meeting of Council, Minutes of the Head Office and Journal Committee had been sent each month to all members of Council so that they were kept fully informed of the Committee's activities. Attention, however, was to be drawn to certain items which had appeared in the Minutes and which were now submitted to Council for noting and such decision as might be necessary. *Noted.*

37. *Congress:* As was usual, the Secretary and the Editor had attended the Congress in Port Elizabeth in June. In addition, Mr. de Kock, the Business Manager, has been sent in order that he might make business contacts with the Trades Exhibitors. The amount of goodwill built up as a result of his visit had been considerable and its good effects had already been seen. At the request of the British Medical Association, a member of the Head Office staff had attended the Congress in order to display a number of journals and periodicals published by that Association. All expenses in this connection had been borne by the British Medical Association.

In this regard Dr. Schaffer mentioned that one of the Trades Exhibitors had felt that the Association was competing with him in undertaking to display and sell books for the British Medical Association. In reply, the Secretary stated that a complaint had been made to him at the time, but he understood that the complaint was not supported by other Trades Exhibitors. He added that one of the objects of the Association was to provide service to its members and that if the members asked the office to order British Medical Association journals for them, the office would undertake to do it. This had been the case in the past and there was no reason why any departure from accepted practice should ge made. *Noted.*

38. '*History of Medicine in South Africa*': The work in this connection was proceeding apace, but while the notes prepared by Col. Graham Botha with reference to the Union Archives dealt mostly with the Cape from the early times, Dr. Burrows had found it necessary to seek more information regarding the development of medical activities in the other Provinces. To this end, he had had considerable correspondence with librarians and historians in those areas, and at the suggestion of those persons he had proceeded on a tour in order that the original documents and sources might be examined personally. With the progress that had been made, it was probable that the book might be published in 1955. *Noted.*

39. *Durban Agency:* Although it was agreed that an Agency Manager should be appointed in Natal, this appointment had been held up owing to the difficulty of obtaining a firm assurance from the Natal Coastal Branch that accommodation would be provided for the Agency free of charge by the Branch. The salary to be paid to a full-time Agency Manager would probably result in this Agency running at a loss for some time, and the Committee felt that it could not commit the Association to any extra loss that might result from having to provide office accommodation in addition.

Dr. Grant-Whyte said that the Natal Coastal Branch was unable financially to support an Agency in Durban and that, if the agency was to continue, the Association would have to accept full financial responsibility for it.

After discussion, it was proposed by Dr. Sichel, seconded by Dr. J. S. du Toit, that the previous resolution of Council, giving authority for the appointment of an Agency Manager in Durban be rescinded and that in the meantime the work of the Durban Agency be transferred to Cape Town.

An amendment was proposed by Mr. Cole Rous, seconded by, Dr. Broomberg, that the Agency should be transferred to Johannesburg.

On being put to the vote, the amendment was *lost*. Dr. Sichel's proposal was then put to the vote and *carried.*

Council adjourned at 6.5 p.m.

## FRIDAY, 29 OCTOBER

The meeting commenced at 9 a.m., and consideration of the Report of the Head Office and Journal Committee was resumed:

40. *Advertising:* Early in August, the Business Manager had visited the Transvaal as part of his duty of keeping in touch with advertisers and advertising contractors. The importance of the Business Manager visiting advertisers and contractors in other centres, in addition to those he could easily contact in Cape Town,

was recognized and the Committee had agreed that it would be to the Association's benefit for him to pay visits to the chief centres of the Union at least annually, in order to obtain new advertising contracts and maintain those at present in existence. *Noted.*

41. *Transfer of Associate Secretary:* The Associate Secretary had been sent to the Transvaal in August in order to investigate the position as regards the work which was said to have been outstanding. He had submitted a report which had been circulated with the Minutes of the August meeting of the Committee and which members would have had the opportunity of studying. The Committee accordingly recommended to Council:

'1. That while it is not the function of the Head Office, or the Association as a whole, to provide an official to do work which is essentially that of a Branch under our present Organization, there is no reason why any Branch or group of Branches should not appoint a full-time official at their own expense if they find that pressure of their work warrants such an appointment.
2. That the Federal Council should authorize members undertaking Committee work on its behalf to obtain such clerical assistance as may be necessary from time to time, at the expense of the Council.'

Discussion followed on the first recommendation, and it was proposed by Dr. Broomberg, seconded by Dr. Deale, 'That a permanent official be appointed, with headquarters located in the Transvaal, primarily to deal with all forms of Contract Practice as they affect relations between the Association, employers of labour and any other organizations designed to provide contractual medical services.'

An amendment was proposed by Mr. Wolfowitz, seconded by Dr. Heymann, 'That the Federal Council appoint a senior, permanent, full-time official in the Transvaal to deal with Contract Practice and other Association matters.'

After further discussion, and with the consent of his seconder, Dr. Broomberg withdrew his motion. The amendment became the substantive motion and was put to the vote and *carried nem. con.*

It was proposed by Dr. Sichel, seconded by Dr. Waks and *resolved* that it be an instruction to the Head Office and Journal Committee to go into the whole question of implementing the principle which had now been adopted, and to refer it to the Executive Committee with power to act.

Council then considered the second recommendation made by the Head Office and Journal Committee in regard to payment for clerical assistance. On being put to the vote, the recommendation was *adopted.*

42. *Locale of the Head Office:* The Secretary stated that in accordance with the instructions of Council, the matter had been referred to the Branches. He read the letters of reply which had been received from some Branches.

It was proposed by Dr. Landau, seconded by Mr. Armitage, that the locale of the Head Office remain in Cape Town.

After some discussion, an amendment was proposed by Dr. Waks, seconded by Dr. J. G. A. du Toit, 'That by virtue of the decision of Federal Council to appoint a full-time official to deal with Association matters in the Transvaal, the question of the locale of the Head Office be left in abeyance and that the whole question be reviewed in the light of this experiment.'

Dr. Schneider then moved the previous question, being seconded by Dr. J. S. du Toit. On being put to the vote, this was *carried* with two dissentient votes.

The Chairman then welcomed Dr. J. J. du Pré le Roux, Secretary for Health, and his Deputy, Dr. B. Maule Clark, and stated that they had been invited by the Executive Committee to be present in order to discuss certain matters with members of Council.

43. *Habit-forming Drugs and Potentially Harmful Drugs:* The attention of members was drawn to a memorandum which had been circulated by the Parliamentary Committee and which had received the approval of the Secretary for Health.

Dr. le Roux mentioned a number of the difficulties which faced his Department in carrying out the law as it stood, and the necessity of co-operation from medical practitioners.

Several members asked questions which were answered by Dr. le Roux. In reply to a question by Dr. Ross regarding the labelling of medicine bottles with the name and address of the doctor dispensing the medicine, the Secretary for Health said that he would enquire into the matter and write to the Secretary of Council so that his reply could be published in the *Journal* for general information.

The Chairman thanked Dr. le Roux and stated that the Executive Committee recommended that the memorandum prepared by the Parliamentary Committee be published in the *Journal. Council agreed.*

44. *District Surgeons:* Dr. Struthers mentioned the grievances of the district surgeons in regard to their emoluments, and was supported by a number of members, who spoke of the unsatisfactory conditions under which district surgeons worked.

In reply, Dr. le Roux mentioned what had been done recently for the district surgeons and stated that his Department wanted figures on which to base any increments. He added that every case would receive sympathetic consideration, a statement which *Council noted with acclamation.*

There being no further questions, the Chairman thanked Dr. le Roux and Dr. Maule Clark for having attended the meeting, adding that he hoped that some good might come of the discussions which had taken place. Council accorded a *vote of thanks, with acclamation.*

In reply, Dr. le Roux thanked the Council for the opportunity given him to be present and stated that if he could be of assistance at any time the Council should call on him.

Drs. le Roux and Clark then left the meeting.

### MANAGEMENT COMMITTEE OF THE BENEVOLENT FUND

Dr. Sichel presented the Report of this Committee, stating that three meetings of the Committee had taken place since the last report had been made to Council, the average attendance being seven members.

45. *New Grants:* The Committee recommended to Council that Mrs. M.A.L. and Mrs. B.R. (both of the O.F.S. and Basutoland Branch) be granted £10 per month each, the former as from 1 May 1954 and the latter from 1 April 1954. These grants had received the approval of the Executive Committee and required confirmation by Council. Council accordingly *confirmed* the grants.

The Committee also recommended that Mrs. B.M.H. (Natal Coastal Branch) be granted £12 10s. 0d. per month as from 1 September 1954. Council *agreed.*

The Committee further recommended that Mrs. P.A. (Cape Eastern Branch) be granted £15 per month as from 1 October 1954. Council *agreed.*

46. *Application Forms for Grants:* At the request of the Southern Transvaal Branch, the Committee had instructed the Secretary to draw up a set of notes for the guidance of Branch Secretaries in the filling of application forms. This matter was receiving attention. *Noted.*

47. *Accruals to Fund:* Up to the end of August, two legacies, each amounting to £500, had been paid to the Fund from the estates of the late Drs. A. Frew and A. M. Pollock. Votive Cards (In Memoriam) had brought in £125, Acknowledgment Cards for Services Rendered, £185; and Donations had amounted to £317. *Noted.*

At this stage the Vice-Chairman announced that Dr. Ziady had sent an apology for absence as his mother had passed away. The Secretary was asked to send a letter of condolence to Dr. Ziady on behalf of the Council.

### PARLIAMENTARY COMMITTEE

Dr. Struthers presented the Report of this Committee.

48. *Fees for Medical Services:* Dr. Struthers reminded members of the agreement which had been confirmed at the last meeting of Council in regard to the medical treatment of personnel and dependants of the South African Police Force, and stated that similar arrangements had been made with the Secretary for Education, Arts and Science, for the treatment of children in industrial schools, etc.; the Surgeon General, for Union Defence Force personnel; the Commissioner of Pensions; the Secretary for Health, for services to work colonies, mental hospitals, leper institutions, etc.; and the Director of Prisons, for all staff personnel.

The action of the Committee was *confirmed,* and *Council also agreed* that the medical treatment of prisoners should be dealt with on the same lines.

49. *Discount on Accounts under £2 2s. 0d.:* It was reported that the Commissioner of Police had agreed that there would be no percentage reduction on any account of £2. 2s. 0d. or less in respect of services rendered to any one patient on or after 1 November 1954. Dr. Struthers stated that an attempt was being made to

obtain the same assurance from the other Government Departments. *Noted.*

50. *Incompleteness of the Medical Aid Tariff Book:* It was pointed out that the Tariff book was incomplete in that many fees were not listed in it. This applied particularly to the fees for pathological services, and as the agreement reached with the Government Departments was based on the Tariff book there would be undoubted difficulty in this regard. *Council agreed* that the Pathologists' Group should be asked to endeavour to provide a uniform tariff.

51. *Interpretation of the Agreement—Pensions Department:* In reply to a question, Dr. Struthers stated that there was difficulty in getting the Department of Pensions to interpret the agreement reached, in a way which coincided with the point of view of the Association.

*Council agreed* that the Secretary should take up the matter with the Commissioner of Pensions.

52. *Representation of South-West Africa Practitioners on S.A. Medical and Dental Council:* Dr. Struthers stated that this matter had not been overlooked but that as a new Parliamentary Committee was to have been appointed at the present meeting it had been decided to leave the matter over for action by that new Committee. *Noted.*

53. *Other Matters Dealt with by the Parliamentary Committee:* Council noted that other matters, such as the question of deductions from Income Tax, the Schedules of Poisons and Potentially Harmful Drugs, Workmen's Compensation Act matters and the question of competition between the S.A. Institute for Medical Research and private pathologists, which had all received some attention by the Committee, appeared in other places on the Agenda, so that any references which Dr. Struthers might make would be made at the appropriate times.

Dr. Struthers then moved the adoption of his Report, seconded by Dr. Peskin. This was *carried with acclamation.* Dr. Peskin said that he wished to congratulate Dr. Struthers and his Committee on the fine work which they had done. *Acclamation.*

Council adjourned for lunch from
1.5 p.m. until 2.15 p.m.

REPORTS OF SUB-COMMITTEES

54. *Workmen's Compensation Act Sub-Committee:* The Chairman stated that Dr. Meltzer had not stood for re-election to Federal Council and was thus not a member, but he had been invited by the Executive Committee to present the Report of the Sub-Committee in the circumstances. The Executive Committee had also invited Mr. Lewis, the Workmen's Compensation Commissioner, to be present in order to assist in the discussion regarding the revision of the tariff of fees under the Workmen's Compensation Act.

In reply, Dr. Meltzer said that it had been a privilege and pleasure to work for the Association during the past six years. He thanked the Chairman for his courtesy in allowing him to be present to present his Report. He stated that two meetings had been held with the Commissioner, who had agreed to a 25% increase in the tariff as from 1 January 1955, with the proviso that no further changes would take place for three years, which would give the Commissioner the opportunity of consulting his carriers and seeing how far it would affect the Fund.

The Commissioner explained that the additional amount of money required would be in the neighbourhood of £100,000 a year in addition to such basic increases as had already taken place. It was the custom to hold a financial survey and study of the position of the Accident Fund every three years and for this reason he had specifically asked that no further change should take place for three years.

In the discussion which followed, a question was asked by Dr. Peskin, to which Dr. Meltzer replied that if a particular fee seemed to be inadequate, then the Group, as such, desiring to have it amended, could appeal to the Workmen's Compensation Act Sub-Committee and the Committee would attempt to get the Commissioner to revise any particular fee.

In reply to a further question by Dr. Shapiro as to why it was claimed that preferential rates should apply to treatment under the Workmen's Compensation Act, the Commissioner stated that a total of approximately £1½ million was paid each year for medical aid under the Workmen's Compensation Act, and that, put crudely, it was expected that wholesale rates would apply to a wholesale service. In reply to a further question, he stated that hospital fees were a fraction of the total cost and that the major expenditure was due to payment for medical services.

After further discussion, it was proposed by Dr. Struthers, seconded by Dr. Vercueil and *resolved* that the recommendation of the Committee to accept the 25% increase in the fees set out in the tariff book be *accepted* and that an attempt be made to have the Handbook completely revised within the three years suggested.

Continuing with his Report, Dr. Meltzer stated that the question of free choice of doctor was a very contentious matter. It might be possible to obtain it, but it would only be with the complete co-operation of industry. *Noted.*

In regard to the repudiation of accounts, he felt that settlement could be reached by the new Committee co-operating with the office of the Commissioner. *Noted.*

In conclusion, Dr. Meltzer expressed sincere thanks to Drs. Vercueil and Struthers and Mr. de Bruijn for their co-operation as members of the Sub-Committee, and to Mr. Lewis for the way in which he had always received the Committee at his office and for the cordial spirit which had always prevailed.

The Report was *adopted with acclamation.*

Dr. Vercueil proposed a vote of thanks to the Commissioner, Mr. Lewis, for his friendliness and cordiality, and also to Dr. Meltzer for the hard work which he had done for the Committee during the past six years. This vote of thanks was *accorded with acclamation.*

55. *Appointment of Joint Liaison Committee with Workmen's Compensation Commissioner's Department:* The Chairman said that it would be necessary to appoint a Convener of the Sub-Committee as well as the Joint Liaison Committee.

A ballot was held, and Drs. Segal and Vercueil and Mr. G. T. du Toit were declared elected. Dr. Vercueil was appointed Convener.

On behalf of the Federal Council, the Chairman then thanked Mr. Lewis for having given of his time to come to the meeting, and he expressed the hope that the negotiations between the Association and the Commissioner's Department would proceed expeditiously and smoothly. He also wished Mr. Lewis well in his retirement which was to take place at the end of June, 1955. *Acclamation.*

Mr. Lewis and Dr. Meltzer then left the meeting.

56. *Report of Sub-Committee to Advise Controller of Imports:* The Sub-Committee reported with regret that Prof. F. Forman had been obliged to resign from the Committee for health reasons, and it placed on record its appreciation of the services which he had rendered to the Committee. The vacancy caused by his resignation had not been filled. *Noted.*

The Committee had continued to advise the Department of Commerce and Industries, as well as the Pharmaceutical Advisory Committee on the essentiality and desirability of medical supplies being imported into the Union. Nineteen applications had been considered from importers, covering thirty products, of which five items had not been recommended. Applications for importation of medical supplies not obtainable through the usual trade channels had been considered from six medical practitioners, of which two items had not been supported. An application for importation of special electrical equipment by a lay body had been referred to the Committee but not recommended.

The Sub-Committee's *Report was noted* by Council.

57. *Report of Sub-Committee for Liaison with S.A. Nursing Association:* Council *noted* that the only matter dealt with by this Sub-Committee had already received attention under Minute 15 above.

*Council resolved* that the Federal Council members of the Northern Transvaal Branch would continue to constitute this Sub-Committee.

58. *Report of Sub-Committee on Registration of Specialists:* Dr. Schneider gave details of the results of the questionnaire as had been published in the *Journal.* He stated that his Committee had not met since the questionnaire had been circulated.

The Chairman said that he felt that this was the time to discharge the Sub-Committee and to accord it a very hearty vote of thanks for the onerous work it had done. Council owed a great deal to Dr. Schneider who had acted as Convener and Secretary of the Committee. *Council agreed* that the Sub-Committee be discharged, and a vote of thanks was *accorded with acclamation.*

The Secretary read a letter from the Registrar of the S.A. Medical and Dental Council, in which the Association was invited to express its views to the *ad hoc* committee which was being set up by the

Medical Council on the interpretation of the referendum and in regard to such steps as might be considered should be taken.

The Chairman asked that a resolution be put forward as a basis for discussion, saying that one method might be to rescind all previous resolutions regarding the establishment of a Specialist Register.

Dr. Shapiro moved that all previous resolutions dealing with matters of policy regarding the establishment of a Specialist Register be rescinded. A vote was taken and *Council agreed nem. con.* to rescind all previous resolutions relating to this matter.

Following this, it was proposed by Dr. Shapiro, seconded by Dr. Turton and *resolved* that Council address itself to the consideration of the questions put to it by the Medical Council.

It was then proposed by Dr. Schneider, seconded by Dr. Theron, 'That as a result of the questionnaire regarding the Specialist Register, Council decides (*a*) that it is in favour of a Specialist Register only; (*b*) that the Register be a statutory one, and (*c*) that no domiciliary visiting be done by specialists except in cases of absolute emergency.'

An amendment was proposed by Mr. McMurray, seconded by Dr. Sypkens, 'That the questionnaire shows that in the opinion of the profession there should be a Register of Consultants only.'

A further amendment was proposed by Dr. Shapiro, seconded by Dr. Turton, that the questionnaire be referred back to the scrutineers for a detailed analysis of the voting papers on a basis to be decided by the Council. After discussion, this amendment was put to the vote and *carried*. It was also *carried* as a substantive motion.

Following acceptance of this resolution, it was proposed by Dr. Lane, seconded by Dr. Visser and *resolved* that the results of the analysis be referred back to Council to enable it to formulate a policy, and that Council meet before the next meeting of the Medical Council in order that this might be done.

Council adjourned for dinner at

5.45 p.m. and resumed at 8.30 p.m.

### CENTRAL COMMITTEE FOR CONTRACT PRACTICE

In the absence of the Chairman of the Committee, Dr. Ochse, the Report of the Committee was presented by Dr. Vercueil and considered seriatim:

59. *Fees for Neuro-surgical Operations:* The Neuro-surgeons had agreed that the suggested fee for Anaesthetists (£5 5s. per hour, with a maximum of 30 guineas) was reasonable and should be approved in spite of the fact that it would leave a smaller fee for the other members of the team. The Committee recommended to Council that Medical Aid Societies be advised of the anaesthetic fee and that the total for these operations would thus not exceed the amount stated in the Tariff book as a 'team fee'. *Council agreed.*

60. *Fees for Thoracic Surgery:* The amended schedule submitted by the Thoracic Surgeons had now been accepted by the large majority of Medical Aid Societies, and the Committee recommended to Council that this schedule be now incorporated in the Tariff book. *Council agreed.*

61. *National Medical Aid Society of South Africa:* Notice of Motion had been given at the previous meeting of Council by Mr. Currie, seconded by Dr. J. P. de Villiers, that the resolution on the National Medical Aid Society taken at that meeting be brought under review with a view to its rescission. The rescission of the resolution was then moved by Mr. Currie, seconded by Dr. Shapiro, and *Council resolved* accordingly.

It was then proposed by Mr. Cole Rous, seconded by Dr. Adler and *resolved* that Council go into committee.

After discussion, it was proposed by Dr. Heymann, seconded by Mr. McMurray, that Council go out of committee and confirm the resolutions taken while in committee. *Council agreed.* These were as follows:

That the Constitution of the National Medical Aid Society should be amended in the following way:

1. Section 8(1): That this Section, reading:

> 'Membership of the Society shall be open to all Europeans residing in the Union of South Africa and South-West Africa, provided that members taking up residence in places outside the Union of South Africa or South-West Africa may, at the discretion of the Board, continue their membership',

include the following:

(*a*) The average income of the members of the Society should not exceed £700 per annum.

(*b*) The income of no member of the Society should exceed £2,500 per annum.

(*c*) Only 3% of the members of the Society should have incomes within the range of £1,500 to £2,500 per annum.

(*d*) In assessing the income of any member, the Society should be assured that the wife's income is also taken into account; therefore the income assessed should be the combined income of husband and wife.

(*e*) That the membership of the Society be restricted to salary and wage earners and their families.

2. Section 8 (2)—Associate Membership: That this Section, reading as follows, be deleted so that Associate Membership be abolished:

> 'No person shall be accepted for membership who at the date of his application for membership has already attained the age of 51 years, provided that the Board may in its discretion accept as Associate Members persons over the age of 50 years, on payment of a subscription of £2 2s. per annum. Such Associate Members shall, subject to the provisions of Section 17, be entitled to the benefits of the Tariff of Fees only.'

3. Section 9 (1)—Directors: That the recommendation of the Cape Western Branch that the Medical Association have the right to nominate two directors to the Board of the Society, be not supported.

4. Section 22—Amendments to Constitution: That the Society should incorporate in this clause the statement that all amendments affecting medical services will be referred to the Medical Association for approval before coming into force.

*Council also agreed* (*a*) That the position of the National Medical Aid Society be reviewed from time to time, particularly with a view to the control of the average income of members, to ensure that this does not exceed £700 per annum.

(*b*) That an official check of the Society be made with regard to the average income figure of £700 and the method by which it is calculated, this to be done annually by the Associate Secretary with the assistance of the Association's accountant.

(*c*) That the Society's expressions of willingness to co-operate with and assist the medical profession and to work in amicable collaboration with the Medical Association, be noted. That it be also noted that certain amendments to the membership rules had been transmitted by the Society for consideration by the Association, but that the suggestion had yet to be ratified by a general meeting of the Society.

62. *Legal Opinion*: The Committee reported that legal opinion had been sought, on the suggestion of the Southern Transvaal Branch, as to whether, when two parties entered into an agreement, one party had the right to either alter or rescind the agreement without consideration of the views of the other party.

Council noted that the legal opinion had not yet been received, and left it to the Committee to decide what should be done in the light of the legal opinion.

63. *S.A Association of Medical Benefit Societies:* A memorandum submitted by the Association of Medical Benefit Societies was referred for discussion by Council. The Committee wished to bring to the notice of Council the fact that this organisation's concept of a Medical Benefit Society was one which included all and sundry and did not agree with the Medical Association's idea that it should only include the lower income group. *Noted.*

The suggestion had been made by the Association of Medical Benefit Societies that a sub-committee consisting of representatives of the Medical Association and of the Association of Medical Benefit Societies should meet to work out a basis in detail. It was proposed by Dr. Shapiro, seconded by Dr. Agranat and *resolved* that this suggestion be not approved.

64. *Health Insurance for the Public:* The Southern Transvaal Branch had again suggested that this matter be discussed by Council, and the Committee drew attention to it in the report for that purpose. The Committee was not sure that this fell within the scope of the Association or that it would be correct to undertake the organisation of such a scheme.

It was pointed out that the Association was a non-profit-making company and that as soon as it made money for profit it would have to pay income tax.

*Council agreed* that this matter be *noted.*

65. *New Medical Aid Societies:* The Committee recommended to the Council that the following Societies be approved:

(*a*) The A.T.I. Medical Aid Society, for a probationary period of one year, after which it was to raise the annual limit of benefits. *Council agreed.*

(*b*) The Bloemfontein Municipal Employees Medical Aid Society. *Council agreed.*

(*c*) The Jagersfontein Mine Benefit Society. Council *approved* this Society as a Benefit Society giving specialist services at Medical Aid Society rates.

(*d*) Simmerpan Medical Benefit Society. This Society was *approved* as a Benefit Society giving specialist services at Medical Aid Society rates, provided that proper capitation rates were paid to the medical officers attached to the Society.

66. *Printing Industry Labourers' Sick Benefit Fund:* An application by this Fund for recognition had been received. This recognition was to apply within all Branches of the Association. The application had been considered by all Branches and, with the exception of the Cape Western Branch, all had given approval. The reason for the refusal of the Cape Western Branch to approve this Society was its disapproval of all closed panels. It was noted that the Southern Transvaal Branch had submitted a resolution reading: 'In view of the fact that it can be anticipated that Medical Benefit Societies for non-Europeans will increase in future, the Central Committee for Contract Practice should consider its attitude on the whole question, and that it should sound the feeling of all the Branches in the Union on the matter of open or closed panels for such Societies.' In view of this resolution, the Committee recommended to Council that all Branches should be consulted again accordingly.

*Council agreed* that this matter be referred back to the Committee or to the Executive of the Committee, for action.

The Associate Secretary informed Council that another Society was seeking recognition from the Association and was also accepting members all over the country. So far not all the documents had been received for perusal. *Noted.*

67. *New Rules:* The Committee recommended the addition of the following clauses to the Rules to which Medical Aid Societies should conform:

(*a*) That no group or organisation be recognised as a Medical Aid Society which is not confined to a single unit such as a firm, company or similar body. Should such a firm, company, etc., wish to incorporate any group of people or any individual/s not directly employed by such firm, company or similar body into the Medical Aid Society, permission for such incorporation must be obtained from the Medical Association of South Africa.

It was proposed by Dr. Shapiro, and Council *agreed*, that this rule be preceded by the words: 'That except by resolution of the Federal Council'.

*Council agreed* to this addition as amended.

It was further recommended by the Committee that the following rule be incorporated into the Association's Rules:

(*b*) That the Association has the right to review the Constitution of any Medical Aid Society from time to time as it deems fit, and that it be a condition of approval that all Medical Aid Societies shall at any time furnish any information required.

*Council agreed*, with the proviso that legal opinion be obtained with regard to this proposed rule, to ascertain whether it would hold good in law.

68. TARIFF OF FEES

(*a*) *Fees for Radiology:* The Committee stated that the following additions to the Tariff had been submitted by the Radiological Society of South Africa:

| | £ | s. | d. |
|---|---|---|---|
| *Cerebral Angiography:* | | | |
| For one or two series of films | 8 | 8 | 0 |
| For each extra series | 3 | 3 | 0 |
| *Arteriography, Peripheral:* | | | |
| Assuming the radiologist does not perform the injection | 6 | 6 | 0 |
| *Angiocardiography:* | | | |
| Where the injection is done by physician: | | | |
| For the first series | 12 | 12 | 0 |
| For each further series in another plane | 5 | 5 | 0 |
| Where injection is done by radiologist extra | 3 | 3 | 0 |
| *Aortography:* | | | |
| Where injection is done by surgeon | 6 | 6 | 0 |
| Where injection is done by radiologist | 11 | 11 | 0 |
| *Venography* | 6 | 6 | 0 |

Although some of the above fees were relatively high, it was pointed out that those cases were time-consuming and required elaborate techniques and, in some cases, expensive equipment which was used infrequently.

The Committee recommended that this schedule be submitted to approved Medical Aid Societies for their acceptance.

*Council agreed* with these fees, provided that they integrated with the fees of the Physicians and Surgeons for Aortography.

(*b*) *Confinement Fee for Multiple Birth:* The Committee recommended that the fee for normal cases of multiple birth should be the same as for normal confinements. *Council agreed.*

(*c*) *Otorhinolaryngology:* The Committee recommended that fees for general practitioners shall be two-thirds of the fees for specialists, provided that no fee shall be reduced to less than £8 8s. and that fees of £8 8s. and less shall not be subject to reduction. *Council agreed.*

(*d*) *Fees for Arteriography and Myelography:* The Committee recommended the addition of the following fees to Section 'M' of the Tariff book:

| | |
|---|---|
| Arteriography | £15 15s. |
| Myelography | £5 5s. |

These fees should be regarded as fees for diagnostic procedures, and operation fees may be charged subsequently.

*Council agreed* to refer this matter back to the Committee for further report.

(*e*) *Sonostat Treatment:* The Committee recommended that this item be added to Section 'X' of the Tariff book, with a fee of £1 1s. *Council agreed* that this matter be referred back to the Committee for further report.

(*f*) *Fees for Pathology:* The Committee reported that the Northern Association of Medical Aid Societies had refused to pay accounts for pathologist services in the Cape and Natal on the basis of the schedules for those areas, but would only pay on the Transvaal tariff which they held to be the only schedule on which they had negotiated with the Association. The Committee felt that accounts should be paid according to the schedule on which they were rendered.

Dr. Shapiro moved that the matter be referred back to the Pathologists' Group in order that further efforts be made to reach a uniform tariff applicable throughout the Union. On being put to the vote, this was *carried with one dissentient vote.*

69. *General Motors Sickness and Accident Benefit Fund:* The Committee reported that this Fund, which had been in existence for almost 20 years, had never formally been approved by the Association. When it had been decided to regularise the position with the local Branch of the Association, due regard had been given to the requirements of the Association that a benefit scheme should not be underwritten by an insurance company. On submission of the scheme to General Motors overseas office in New York, approval had been withheld, it being insisted that it was contrary to corporation policy to carry its own insurance, whether in that or any other activity. In the case of this Fund, the premiums paid were adjusted periodically in accordance with claims experience, so that there was no opportunity for a large profit to be made by the insurance company. The members of the Fund all belonged to the low income group who would, to a large extent, fall into the hospital or free patient category. If recognition was not given, the Fund might have to be abandoned and the members would become hospital cases, with consequent financial loss to the medical profession. The Committee therefore recommended that in the special circumstances this Fund be approved as long as the corporation's policy was directed from the United States of America.

The question arose as to whether it was a closed panel Fund, and Dr. Vercueil stated that it was a limited open panel Fund.

*Council agreed* that the matter be referred back to the Committee for further consideration.

70. *Average Income for Members of Medical Aid Societies* A request had come from the Northern Association of Medical Aid Societies that the Association should give reconsideration to the amount of £700 laid down as the average income for membership of Medical Aid Societies.

*Council noted* this request.

71. *Thoracic Surgeons Panel for S.A.R. & H. Sick Fund:* The Committee reported to Council that the thoracic surgeons had agreed to an appointment in Johannesburg where there were more

than 10,000 members, in spite of the fact that Council had ruled that a panel for a specialist should not consist of more than 10,000 members.

*Council agreed* that the Thoracic Surgeons' Group and the S.A.R. & H. Sick Fund be informed of the previous ruling of Council.

72. *Appointment to Durban Corporation:* The Committee recommended that Council should make representations to the proper authorities that suitable remuneration be paid to part-time medical officers doing immunization work for local authorities. *Noted.*

73. *Membership Figures: Council noted* that there were only 133 Societies in operation, although 136 were approved. Replies to the questionnaire had been received from all but 13 Societies. It was shown that 120 Societies consisted of 106,875 members and 120,114 dependants. In addition there were approximately 10,000 European Police and 11,000 non-European Police, having approximately 20,000 dependants. The Prisons Department consisted of approximately 2,500 European personnel and 1,000 non-European personnel, having approximately 10,000 dependants. The estimated grand total for all these was 281,489.

Council adjourned at 11.30 p.m.

## SATURDAY, 30 OCTOBER

The meeting commenced at 8.45 a.m.

The Secretary read an extract from a letter from the President of the S.A. Medical and Dental Council, conveying good wishes for a successful meeting. *Noted.*

74. *Report of Sub-Committee for Liaison with Pharmaceutical Society of South Africa:* Dr. Vercueil, said that he had approached the Society, which had stated that it had no problems for discussion at present. *Noted.*

75. *Report of Sub-Committee on Rehabilitation:* Mr. G. T. du Toit, the Convener of the Sub-Committee, reported that during the year the Committee had devoted much of its energy to the success of the Plenary Sessions of the Congress at Port Elizabeth, when several of the members of the Committee had spoken on various aspects of rehabilitation. The resolutions passed at the Congress had been based on the discussions held by the Committee in dealing with the Report of the National Conference on Handicapped Persons which had been published in 1952. He asked that the Secretary read a letter from the Secretary for Labour on this subject, in which it was asked that the Association should nominate three of its members so that the Minister of Labour might choose one to represent the Association on the South African Rehabilitation Council.

The Secretary read a further letter from the Secretary of the Rehabilitation Committee, in which it was recommended to Council that the three names to be put forward to the Minister should be Mr. G. T. du Toit and Drs. C. Adler and E. B. Woolf. *Council agreed* that these three names should be submitted to the Minister as the nominees of the Association.

76. *Paraplegic Centre in the Transvaal:* Dr. Struthers stated that the question of establishing a Paraplegic Centre in the Transvaal had been placed before the Parliamentary Committee. He had felt that the subject should not be discussed by his Committee but should either be dealt with by the Council or the Rehabilitation Sub-Committee. *Council agreed* that it be referred to the Sub-Committee on Rehabilitation, with power to act.

77. *Report of Sub-Committee on Medical Fees for Private Practice:* Dr. Landau, the Chairman of the Sub-Committee, reported that the Committee had met on only one occasion since the last meeting of Council. He stated that a number of the Branches had not yet submitted schedules of their customary fees, and as a result it had not been possible to make an analysis. He reported that two members of the Committee had not been re-elected to Council and suggested that the vacancies be filled. *Council agreed* that Drs. Lee and Fehrsen fill the vacancies.

The Chairman asked that members should see that their Branches sent their schedules of customary fees to the Committee as soon as possible. *Noted.*

78. *Report of Vigilance Sub-Committee:* In the absence of the Chairman of the Committee, Dr. Adler stated that the Report in the Annexures was the Report of the Sub-Committee. This Report referred to various fees which it was suggested should apply to part-time specialists to Benefit Societies.

Various criticisms were expressed, and it was proposed by Dr. Struthers, seconded by Mr. McMurray, that the Report be not accepted and that the work undertaken by this Committee should be done in future by the Committee established at the present meeting.

An amendment was proposed by Dr. Vercueil, seconded by Dr. Turton, that the fees suggested in the Report be adopted as a basis for further discussion.

On being put to the vote, the amendment was *lost.* When Dr. Struthers's resolution was put to the vote, it was *carried nem. con.*

Dr. Adler then proposed a vote of thanks to the Sub-Committee, and in particular to Dr. Agranat for the valuable work which he had done as Chairman. He was seconded by Dr. Struthers and the vote was *accorded with acclamation.*

79. *Mines Benefit Society—Confinement Fees:* Dr. Vercueil spoke in favour of the rescission of a resolution taken at the previous meeting of Council, and received some support.

Dr. Shapiro proposed, 'That Council reaffirms that it disapproves of the arrangement entered into between the Mines Benefit Societies Medical Officers' Group and the Mines Benefit Society in connection with confinement fees.' On being put to the vote, this was *carried* by 14 votes to 6.

80. *Full-time Appointments to Benefit Societies:* The Chairman pleaded for a certain amount of elasticity in connection with the policy of the appointment of full-time medical practitioners to Benefit Societies.

It was proposed by Dr. Shapiro, seconded by Dr. Turton and *resolved,* 'That the same principles as have been laid down for the Vanderbijlpark Medical Benefit Fund shall apply to all other Benefit Societies.'

### NOTICES OF MOTION

81. *Amendment of By-Laws 4(a) and 5:* The Secretary stated that in accordance with procedure, the proposed amendments had been submitted to the Branches.

By-Law 4(*a*) was to be amended by the deletion of the words 'if elected' in the second line, so that it would now read: 'Every candidate for membership of the Association shall apply for election in writing addressed to the Association, stating his agreement to abide by the Regulations and By-Laws, and the Rules of the Division and Branch to which he may at any time belong, and to pay his subscription for the current year.'

On being put to the vote, this was *carried nem. con.*

Present By-Law 5 was to be deleted and replaced by a new By-Law 5 reading: 'If legally qualified practitioners applying for membership are duly proposed and seconded by members of the Association, the Secretary shall forthwith declare them to be duly elected.'

On being put to the vote, this was *carried nem. con.*

82. *Amendment of By-Law 6:* The Secretary reported that in accordance with procedure, the proposed amendment had been submitted to the Branches. By-Law 6 was to be amended by the addition of a sub-paragraph (*c*) reading: 'Members who have served the Association continuously for at least 45 years shall become Life Members.'

On being put to the vote, this was *carried nem. con.*

83. *Amendment of By-Laws 23 and 28:* The Secretary stated that in accordance with procedure, the proposed amendments had been submitted to the Branches.

By-Law 23 was to be amended by the insertion of the words 'President or' before the word 'Chairman' in the first line, and the addition after the same word of the words 'a Vice-President or Vice-Chairman', so that it would now read:

> 'Each special Group shall appoint office-bearers consisting of a President or Chairman, a Vice-President or Vice-Chairman, an Honorary Secretary and Treasurer, and an Executive Committee of not less than three members, to control the affairs of that Group. A list of such office-bearers, together with a complete list of the members of the Group, shall be furnished annually to the Medical Secretary within 30 days of the election of such office-bearers.'

On being put to the vote, this was *carried nem. con.*

By-Law 28 was to be amended by the addition of a sentence reading: 'A Group may elect to Honorary Membership of the Group persons of eminence who are not domiciled in the Union, provided that they are medical practitioners and members of their own national medical associations.'

On being put to the vote, this was *carried nem. con.*

HONOURS

84. *Emeritus Membership—Dr. Hamilton W. Dyke:* The Secretary read a letter and citation from the O.F.S. and Basutoland Branch, recommending that Dr. H. W. Dyke be elected to Emeritus Membership of the Association.

It was proposed by Dr. Theron, seconded by Dr. Serfontein and *resolved nem. con.*, that Dr. Dyke be elected to Emeritus Membership of the Association.

85. *Bronze Medal—Mr. L. R. Broster, F.R.C.S.:* The President (Dr. Lane) moved that the rules governing the award of the Bronze Medal be suspended. This was seconded by Dr. Schaffer, and Council *agreed nem. con.*

The Chairman then spoke of the work which Mr. Broster had done on behalf of South African students in the United Kingdom. He said that Mr. Broster was a South African who had been a Rhodes Scholar and had elected to remain and practise in England. In spite of this, he had always retained his connections with South Africans in every way. For many years he had represented the earlier Association on the Representative Body of the British Medical Association. The Chairman said he felt that the Association should express its appreciation to Mr. Broster in a tangible way, and he proposed accordingly that the Bronze Medal of the Association be awarded to Mr. Broster.

The proposal was seconded by Dr. Lane, and Council *resolved unanimously* that Mr. Broster be awarded the Bronze Medal.

HEALTH SERVICES

86. *Cape Province:* Dr. Sichel, Chairman of the Cape Augmented Executive Committee, reported that a Draft Hospitals Ordinance was in course of preparation. The Cape Western Branch, and the Secretary acting on behalf of the Augmented Executive Committee, had written to the Hospitals Department reminding them of the undertaking that, should there be any proposed amendments to the Ordinance, or should there be a new Ordinance, the Medical Association would have an opportunity of commenting on it. An assurance had been received from the Director of Hospital Services in the Cape that an opportunity would be afforded to the Association. *Noted.*

87. *Transvaal:* Dr. Struthers presented the Report of the Transvaal Augmented Executive Committee. He stated that a Commission of Enquiry into Hospital Matters in the Transvaal had been set up and that he had been informed that a questionnaire was to be issued by the Commission, to which the Branches of the Association in the Transvaal would be asked to reply. In due course the Association would present its views to the Commission of Enquiry. Representations had also been made to the Director of Hospitals in the Transvaal in regard to a circular which had been sent out from his Department regarding co-operation by medical practitioners. It was felt that this circular had been misrepresented in the Press, and the representations were designed to prevent misunderstanding in the future.

Dr. Struthers went on to speak of pathological services in the Transvaal and mentioned a meeting which had taken place with Provincial representatives in an effort to find a place for private pathologists in the hospital system. Discussion followed, and Dr. Schneider asked that the Transvaal Augmented Executive Committee should bring this matter to the notice of the Commission of Enquiry when it made its representations.

The Secretary read a letter from the Honorary Secretary of the Pathologists' Group regarding this matter.

It was proposed by Dr. Peskin, seconded by Dr. Vercueil, that the Augmented Executive Committee request the Director of the S.A. Institute for Medical Research to meet them to discuss the question of pathological services.

After discussion, an amendment was proposed by Dr. Shapiro, seconded by Dr. Adler, that the Pathologists' Group be invited to submit to the Executive Committee a memorandum on the difficulties experienced by them in respect of competition by institutions, and that the Executive Committee take such action as may be necessary.

On being put to the vote, the amendment was *carried nem. con.* It was also *carried* as a substantive motion.

Dr. Adler said that as the pathologists had asked for representation when matters affecting them were to be dealt with, they should be invited to furnish their opinions when representations were made to the Commission of Enquiry. *Council agreed.*

88. *Constitution of Augmented Executive Committee in the Transvaal:* Dr. Struthers proposed that the Augmented Executive Committee in the Transvaal be reconstituted. It was further suggested that the Committee should consist of the Executive Committee members in the Transvaal, with four additional members—one for each of the Transvaal Branches and one to represent the Platteland.

*Council agreed*, and further *agreed* that the additional members should be Drs. Schneider, Turton, Waks and Sypkens.

89. *Natal:* Dr. Deale reported that discussions would shortly take place with the Natal Inland Branch regarding Hospitalisation affairs in the Province, and a report would be made to the next meeting of Council. *Noted.*

90. *Orange Free State:* Dr. Theron stated that there was nothing to report from his Province. *Noted.*

S.A. MEDICAL CONGRESS

91. *S.A. Medical Congress, Port Elizabeth, June* 1954 Dr. Lane submitted a report, together with certain suggestions made by Dr. Jabkovitz as Chairman of the Organising Committee of the Congress.

The *report was noted* by Council, and it was *agreed* that the Secretary should furnish a copy of the suggestions to the Honorary Secretary of the Branch in whose area the next Congress would be held.

On the proposal of the President, a vote of thanks was *accorded with acclamation* to the Cape Midlands Branch for their invitation to hold the Congress in Port Elizabeth.

92. *S.A. Medical Congress*, 1955: The Secretary stated that two invitations had been received—one from the Natal Coastal Branch and one from the Northern Transvaal Branch. As the Northern Transvaal Branch wished to arrange for a Congress to take place in Pretoria in October 1955, in order to coincide with the centenary of that city, the Natal Coastal Branch had agreed to stand down in favour of the Transvaal plans.

*Council accepted with acclamation* the invitation of the Northern Transvaal Branch to hold the next Congress in Pretoria from 17-22 October 1955, and also the invitation of the Natal Coastal Branch to hold the following Congress in Durban in 1956.

MATTERS REFERRED TO OR BY BRANCHES

93. *Fees Payable to Part-time Medical Officers at Clinics:* The Secretary submitted correspondence and stated that the matter had been referred to in the second-last item of the Report of the Central Committee for Contract Practice. He read the recommendation of the Executive Committee that the matter should be referred to the Parliamentary Committee for any action which might be considered necessary. *Council agreed.*

94. *Dissemination of Information:* A resolution from the Natal Coastal Branch was submitted, requesting Federal Council to ensure that in future information contained in the Government Gazette, having a special bearing on the interests of the members of the Medical Association of South Africa, should be given early prominence in the *S.A. Medical Journal. Council agreed.*

95. *Public Addresses:* A letter and a memorandum on this subject had been submitted by the Northern Transvaal Branch. The Secretary stated that the Executive Committee recommended to Council that this matter be noted and that the attention of Branch Secretaries be drawn to the memorandum. *Council agreed.*

96. *Goldfields Division of the O.F.S. and Basutoland Branch:* The Secretary reported that the O.F.S. and Basutoland Branch recommended that a new Division in its area be recognized, which would incorporate those areas which comprised the Orange Free State Goldfields. He stated that the Executive Committee recommended to Council that the formation of this Division be approved in principle, and that the details of its Constitution be left to the Executive Committee for confirmation. *Council agreed.*

97. *Appointments to Secondary, Primary and Nursery Schools:* The Secretary stated that there had been considerable correspondence on this subject, which had eventually resolved itself into two questions: The Southern Transvaal Branch wished Federal Council to consider the question of whether specialists should be eligible for appointment as school medical officers, and the S.A. Medical and Dental Council wished Federal Council to define the age at which a child became an adolescent.

In regard to the first question, the Secretary stated that the Executive Committee recommended that specialists should not hold such appointments, even in nursery schools.

After discussion, it was proposed by Dr. Shapiro, seconded by Dr. Schneider and *resolved nem. con.*, 'That Council expresses its opinion that it is undesirable that specialists should hold appointments as part-time school medical officers.'

Further discussion followed in connection with nursery schools. It was proposed by Dr. Peskin, seconded by Dr. Adler and *resolved nem. con.*, 'That it is undesirable for any practitioner in practice to hold a part-time appointment to a private nursery school.'

In connection with the query raised by the S.A. Medical and Dental Council, it was proposed by Dr. Heymann, seconded by Dr. Landau and *resolved* 'That, whereas in law in terms of the Children's Protection Act, with certain exceptions, a person is regarded as a child until the nineteenth birthday and presumably an adolescent between that age and the age of majority at 21 years, physiological development does not synchronise so exactly with this age development. It would be reasonable, however, in most circumstances to regard a person as a child while still at school, though individual problems would of necessity have to be viewed in the context in which they arise.'

98. *Cost of Legal Defence in Criminal Charges Against Doctors:* The Secretary explained that a request had been made by the Southern Transvaal Branch and the Anaesthetists' Group that the scope of the present Public Liability policy should be extended to cover possible charges in the Criminal Courts arising out of the actions of doctors. A letter from the Atlas Assurance Company was read, and the Secretary stated that the Executive Committee recommended that the Secretary go into the matter and submit a memorandum to the Executive Committee, incorporating the opinion of the Federal Council. *Council agreed* to the recommendation of the Executive Committee.

Dr. Shapiro stated that the particular difficulty which had arisen out of the case to which reference had been made was that a charge of culpable homicide had been made against the doctor before an inquest had been held. He felt that it was necessary to point out to the Department of Justice that an inquest should first be held before a charge was laid. He proposed, seconded by Dr. Schneider, that this question be taken up by the Secretary with the Minister of Justice. *Council agreed.*

99. *District Surgeons' Fees:* The Secretary stated that the Transkei Branch had resolved as follows: 'That on behalf of the District Surgeons Group of our area, the Transkei Branch requests that Federal Council appoint a sub-committee to go into the whole question of district surgeons' fees and remunerations, the latter to make certain recommendations to Council.' A resolution had been received from the District Surgeons' Group too late to be included in the Agenda. This resolution read: 'That Federal Council be requested to investigate the matter of fees and allowances of district surgeons.' A memorandum had been submitted by Dr. Serfontein, Chairman of the District Surgeons' Group, which contained some salient points in connection with the district surgeons' grievances.

Dr. Struthers stated that the Secretary for Health had received a letter from the District Surgeons' Group, and the matter was being investigated. If the district surgeons would submit a memorandum containing all their grievances, with recommendations as to how these should be remedied, the Parliamentary Committee would arrange for an interview with the Secretary for Health.

After discussion, *Council agreed* that the District Surgeons' Group should submit a memorandum to the Secretary of Council so that action might be taken by the Parliamentary Committee. It was further *agreed* that in any representations which might be made by the Parliamentary Committee, representatives of the Group should be asked to take part.

### MATTERS REFERRED TO OR BY GROUPS

100. *Remuneration for Anaesthetics—S.A.R. & H. Sick Fund:* A resolution from the Anaesthetists' Group was submitted, in which attention was drawn to the inadequate salaries offered by the S.A.R. & H. Sick Fund. It was stated that the matter had been referred to the Railway Medical Officers' Group but that no satisfactory conclusion had been reached.

It was proposed by Dr. Struthers, and *Council agreed*, that the matter be referred back to the Anaesthetists' Group in order that an equitable fee should be suggested.

Dr. Turton stated that the Railway Medical Officers' Group would be ready to negotiate again as soon as this was known.

101. *General Practitioners' Group—New Section 80 of Medical, Dental and Pharmacy Act:* The Secretary reported that the Group had asked that this item be placed on the Agenda and that further information was said to have been forthcoming.

Dr. Shapiro stated that the Group had not yet been able to prepare its report.

*Council agreed* that the report should be taken at the next meeting, if it had been prepared by that time.

102. *Medical Officers of Health Group—Amendment of Constitution:* The Secretary stated that the Medical Officers of Health Group desired to amend its Constitution by adding a sub-section (iii) to Section 3—Membership, to read:

> 'One or more Honorary Vice-Presidents may be elected at a General Meeting of the Group, subject to the following conditions:
> (*a*) Each such Vice-President elected shall have been a member of the Group in good standing for not less than ten years;
> (*b*) shall have held a full-time public health post or posts;
> (*c*) shall have retired from the post.'

The Secretary stated that the Executive Committee recommended to Council that the amendment be approved. *Council agreed.*

103. *Ophthalmological Group—Opticians and Medical Aid Societies* The Secretary referred to considerable correspondence which appeared in the Annexures, from the Ophthalmological Society of South Africa and various Branches, in which attention was drawn to the fact that certain Medical Aid Societies were entering into contracts with certain opticians for the supply of optical services. He stated that the Executive Committee had agreed to recommend to Council that it be the policy of the Association not to agree to contracts being entered into between Medical Aid Societies and unregistered medical auxiliaries.

The recommendation of the Executive Committee was moved by Dr. Sypkens, seconded by Dr. J. S. du Toit, and *Council resolved* accordingly.

104. *Recognition of Thoracic Surgeons' Group:* The Secretary stated that an application had been received from a number of thoracic surgeons for recognition of the Society of Thoracic Surgeons of South Africa as a Group within the Association. He said that the Constitution which had been submitted was in order and that the Executive Committee had agreed to recommend to Council that the formation of this Group be approved. *Council agreed* accordingly.

### MATTERS REFERRED TO OR BY OTHER MEDICAL ASSOCIATIONS

105. *British Commonwealth Medical Conference:* The Secretary reported that an invitation had been received for the Association to be represented at the British Commonwealth Medical Conference which was to be held in Toronto during June 1955. He added that the Executive Committee had agreed to recommend to Council that the Association be represented at that meeting.

*Council agreed nem. con.* that a representative of the Association should attend the Conference.

It was proposed by Dr. Theron, seconded by Dr. Waks and *resolved nem. con.* that the Secretary should again represent the Association at the forthcoming British Commonwealth Medical Conference.

106. *Australasian Medical Congress, Sydney, 1955:* The Secretary stated that an invitation had been received from the Federal Council of the British Medical Association in Australia, to be represented at the Australasian Medical Congress to be held in Sydney in August 1955.

Although it was felt that the Council could not appoint any individual to attend, it was *agreed* to ask a member who might be in Australia at that time to represent the Association. It was further *agreed* that a letter of good wishes should be sent to the British Medical Association in Australia and that that Association be asked to appoint a representative to attend the Congress to be held in Pretoria in October 1955.

### MATTERS REFERRED TO OR BY WORLD MEDICAL ASSOCIATION

107. *Conclusions concerning Relations between Social Security Institutions and the Medical Professions as Adopted by the International Social Security Association:* A memorandum on this subject had been submitted, and the Secretary stated that the Executive Committee recommended to Council that they be agreed to and that the memorandum be noted. *Council agreed.*

108. *Council Investigation of Possibilities for W.M.A.*

*Co-operation in International Occupational Health Services:* A memorandum on this subject had been submitted, and *Council agreed* that the memorandum be referred to the Rehabilitation Committee for information.

109. *Resolution Adopted at 20th Council Session of World Medical Association:* A copy of the resolution was submitted, in which it was suggested that representations should be made to the Governments of countries that there be included among the delegates to the World Health Assembly a representative of the organized medical profession of the country.

*Council agreed* that this resolution be *approved* and acted upon.

110. *Establishment of Funds for General Assembly Delegations:* A memorandum was submitted on the question of providing funds for travel and subsistence for National Association delegates to the General Assemblies of the World Medical Association.

In answer to the request for suggestions from the Association to help the Planning and Finance Committee and the Council of the World Medical Association to solve the problem of the attendance of a delegate from each national member association at General Assemblies and the holding of General Assemblies in distant countries, it was felt that a suitable arrangement might be the same as that which was in operation in regard to the British Commonwealth Medical Conference, where each of the Commonwealth Associations paid in a share of the expenses to a pool. *Council agreed* that this suggestion should be made.

The Secretary stated that the Executive Committee recommended to Council that future Commonwealth Conferences should be held after meetings of the General Assembly of the World Medical Association, as it felt that if the Association was to be faced with expense in sending a delegate to one meeting, the money might as well be used for both purposes. *Council agreed* accordingly.

111. *Code of Medical Ethics—Chapter on Duties of Doctors to Society:* The Secretary stated that the Association was asked to approve or disapprove in principle the addition of a section to this Chapter in the International Code of Medical Ethics. This was:

> 'Certain obligations devolve upon the physician concerning his relation to the health of the community.
>
> In each State the organization most representative of the medical profession should establish, in the framework of its moral obligations, the rules which the profession must follow when it gives its support to Social Institutions which have in view the preservation and improvement of public health.
>
> Individually, when the doctor has accepted these established rules, he must abide by them exactly. It is his duty to bring to the accomplishment of his social functions the same conscience and the same devotion he gives to his patients; and under no circumstances should he utilise his position for the benefit of his private practice.
>
> Any action, which has no political character, tending to preserve the community from any scourge to which it is exposed, should obtain the active approval of the medical group.'

It was felt that the word 'political' needed some definition, and it was proposed by Dr. Solomon, seconded by Dr. Shapiro, that the words 'political character' be better defined in the ultimate paragraph of 'Duties of Doctors to Society' by the insertion of the words 'ideological or party' before the words 'political character'.

The Secretary stated that the Executive Committee recommended to Council that the additional section be accepted. *Council agreed,* subject to the insertion of the words proposed.

MISCELLANEOUS

112. *Letter from S.A. Society of Industrial Health:* The Secretary stated that the Executive Committee recommended to Council that the matter raised by this Society be taken as urgent, and that the recommendation contained in the letter be supported. This was to the effect that Federal Council be requested to seek amendment to Rule 19(1)(c) of the Ethical Rules of the S.A. Medical and Dental Council, in order to ensure that the status of a registered medical practitioner who accepted an appointment with an industrial concern be defined and be in keeping with the honour and dignity of the profession.

*Council agreed* that the matter be taken as urgent. It was further *agreed* that the recommendation of the Executive Committee be *approved* in that the resolution be supported and that an approach be made to the S.A. Medical and Dental Council in this regard.

OTHER BUSINESS

113. *Letter from Professional Provident Society of South Africa:* The Secretary reported that the Society had advised that its Constitution had been altered to make provision for alternate representatives, and it now requested that the Association appoint alternates to Dr. Schneider, its representative on the Board.

*Council agreed* that the matter be taken as urgent.

Dr. Schneider suggested Drs. C. Adler and M. Peskin as his alternates. *Council agreed.*

114. *Memorandum from East Rand Branch on Question of Shortage of Interns: Council agreed* that this matter be not taken.

115. *Letter from Southern Transvaal Branch concerning Metal Box Company:* A letter from the Southern Transvaal Branch was submitted. It was proposed by Dr. Peskin and *agreed* that the matter be taken as urgent.

Dr. Peskin then proposed that the matter be referred to the Executive Committee, and *Council agreed.*

116. *Thanks to Past Members of Council:* The Chairman proposed that a vote of thanks be recorded to the past Vice-Chairman of Council (Dr. L. I. Braun) and all those who had not been re-elected to Federal Council. *Council agreed with acclamation.*

117. *Date and Place of Next Meeting of Council:* Dr. Schaffer proposed that the next meeting be held in Cape Town. *Council agreed.* It was further *agreed* that the exact time of the meeting be left to the Executive Committee, but that it be in the week preceding the meeting of the S.A. Medical and Dental Council.

118. *Thanks:* Dr. Lane, the President, proposed a vote of thanks to the Chairman of Council for his conduct of the meeting, and extended good wishes to him for his new term of office. This was *accorded with acclamation.*

Dr. Sichel in turn thanked the Council for its co-operation, and also thanked Dr. Struthers for his assistance to the Chair. *Acclamation.*

The meeting ended at 1 p.m.

## PASSING EVENTS : IN DIE VERBYGAAN

*Erratum.* The title of Dr. Louis Mirvish's article in the *Journal* of 11 December 1954 (p. 1055) was *The Management of Haematemesis and Melaena.* The word 'upper' was printed in the title in error.

* * *

*Union Department of Health Bulletin.* Report for the 7 days ended Thursday, 9 December 1954.

*Plague, Smallpox:* Nil.

*Typhus Fever, Cape Province:* Two (2) Native cases on the farm Wilgerkloof in the Maraisburg district. Diagnosis confirmed by laboratory examination. One (1) Native case in the Bilatyi location in the Glen Grey district. Diagnosis confirmed by laboratory examination. *Transvaal:* No further cases have been reported from the Nigel district since notification of 11 November 1954. This area is now regarded as free from infection.

*Epidemic Diseases in Other Countries:*

*Plague:* Nil.

*Cholera* in Chittagong (Pakistan); Calcutta (India).

*Smallpox* in Bombay, Calcutta, Jodhpur, Lucknow, Madras (India); Moulmein (Burma); Phnom-Penh (Cambodia); Saigon-Cholon (Viet-Nam).

*Typhus Fever:* Nil.

* * *

*Cape Town Paediatric Sub-Group.* The next meeting of the Cape Town Paediatric Sub-Group will be held on 4 February 1955 in the E Floor Lecture Theatre, Groote Schuur Hospital, Cape Town, when Dr. W. P. U. Jackson will give an illustrated talk on *More Dwarfs, Bony Dystrophies and Inheritance.* Members of the Surgical, Orthopaedic and Endocrine Sub-Groups and others are cordially invited to attend.

*Refresher Course for General Practitioners.* Owing to the large number of applications received for the refresher course for general practitioners that is to be held at the University of Cape Town in January 1955 (17-22), it is regretted that many applicants could not be accepted. It is intended to organize a similar course in the near future. Details will be announced in the *Journal*.

## IN MEMORIAM

REGINALD EDGAR MEAKER, M.B., CH.B., D.P.H. (CAPE TOWN)

The death occurred at Paarl, C.P., of Dr. R. E. Meaker, Medical Officer of Health, Paarl, on 3 December 1954, at the age of 45 years.

Dr. Reginald Edgar Meaker

Born at Somerset East and educated at Gill College and the University of Cape Town, Dr. Meaker graduated in medicine in 1932 and after serving internships at the New Somerset and City Infectious Diseases Hospitals, Cape Town, proceeded to the Diploma in Public Health in 1934.

Having decided upon public health administration as a career, he became Assistant Medical Officer to the Cape Town City Council, and after 2 years was appointed to the joint post of Medical Officer of Health and District Surgeon at Kingwilliamstown.

When the war intervened, he enlisted with the South African Medical Corps, serving as Staff Officer Hygiene in the Cape Command and in 1944 Deputy Director of Medical Services, Northern Command. In October 1945 he retired from the army with the rank of major, and resumed his post at Kingwilliamstown.

Dr. Meaker found that the District Surgeon's work had outgrown the public-health aspect during the war, and he accordingly resigned, to become Assistant Medical Officer with the Pretoria Municipality, and then in the Union Health Department. An opportunity came with the creation of a new post of Medical Officer of Health at Vereeniging, and when he was appointed to it, he dedicated himself to the task of building up a town health department there. He threw himself wholeheartedly into local philanthropic health affairs, serving on numerous committees, and he played a great part in the provision of the modern new municipal abattoir at Vereeniging.

When the combined post of Medical Officer of Health to the Paarl Municipality and Divisional Council was created in 1951, Dr. Meaker shifted his pioneering energies to Paarl, where again he created an efficient department from very humble beginnings.

In his chosen speciality, Dr. Meaker made his mark; he was immediate past-President of the Health Officials' Association of Southern Africa, a member of the Executive Committee of the South African Society of Medical Officers of Health (State Medicine), a Group of the Association, and a member of the South African Institute of Sewerage Purification.

*Dr. F. K. Mitchell, Deputy Medical Officer of Health, Cape Divisional Council, writes:* Public health in South Africa, and in particular the young health department at Paarl, has suffered a grievous loss with the untimely passing of Reg. Meaker.

In the 3 years during which he was Staff Officer Hygiene in the Cape Command, the number of troops in the area rose from thousands to tens of thousands, the number of camps were more than quadrupled, and millions of pounds were spent on camp construction. Each camp had its own hygiene problems, and the fact that a very high standard of hygiene was reached and maintained was due in no small measure to his initiative and forethought and to the capable administration of his Department.

It was not in Reg's nature to sit back and rest, and the fact that he shifted from Vereeniging to Paarl, was due to his impatient urge to organize and break new ground. He had a complex character. He tended to ride roughshod over criticism and red tape and was never one to suffer fools gladly. His subordinates had to give of their best all the time, but they did so gladly because of the example he himself set. The high opinion which his staff had of him can be judged from the fact that when he was taken ill a few months ago, he was serving as President of the Health Officials Association of Southern Africa—the national union of health inspectors.

Reg Meaker's public-spiritedness went far beyond the scope of the various posts he actually filled. He was always seeking opportunities to foster and encourage the many voluntary bodies which, if properly stimulated and guided, can play such an important part in easing the lot of the under-privileged in the community. While at Vereeninging he served on the Hospital Board, and was Chairman of the Dental Board, Chairman of the local branch of the S.A. National Tuberculosis Association, Vice-Chairman of the Child Welfare Society and an Executive Member of the Vroue-federasie, and the Society for the Prevention of Cruelty to Animals.

Reg was a hard worker, a good organizer, and a man who was faithful to his cause—the welfare of his country and his fellow-citizens. And if at times he was impetuous, impatient and irked by red tape, those of us who were privileged to know him understood that he was working against time, striving to do a life-time's work in the condensed span which he well knew was all that the mitral damage sustained in childhood would allow him.

He will be sadly missed by all who knew him, and especially by his many colleagues and junior officials in public health.

To his widow, we extend our sincere sympathy.

## BOOK REVIEWS : BOEKRESENSIES

### CURRENT THERAPY

*Current Therapy* 1954. Edited by Howard F. Conn, M.D. (Pp. 898+xxxii.) Philadelphia and London: W. B. Saunders Company. 1954.

*Contents.* Part I. The Infectious Diseases. Part II. Diseases of the Respiratory System. Part III. Diseases of the Cardiovascular System. Part IV. Diseases of the Blood and Spleen. Part V. Diseases of the Digestive System. Part VI. Disorders of Metabolism and Nutrition. Part VII. Diseases of the Endocrine System. Part VIII. Diseases of the Urogenital Tract. Part IX. The Venereal Diseases. Part X. The Allergic Diseases. Part XI. Diseases of the Skin. Part XII. Diseases of the Nervous System. Part XIII. Diseases of the Locomotor System. Part XIV. Obstetric and Gynaecologic Conditions. Part XV. Diseases Due to the Physical and Chemical Agents. Part XVI. Appendices and Indices. Index.

The problem of keeping abreast of recent advances in therapy confronts all of us. We are constantly bombarded by literature proclaiming the greater value of this product over that and few of us have the opportunity to test the soundness of such claims. From such incessant bombardment confusion may develop in the more credulous and busy mind, to the detriment of that balanced approach so necessary for the practice of good medicine.

In an effort to combat this *Current Therapy* is published annually. An imposing list of 379 experts and 13 consultants combine to provide concise and sufficiently detailed information on a wide range of subjects to suit general practitioners, physicians, dermatologists and obstetricians particularly. This information is

# Instructions to Authors

All authors are advised to consult *Medical Writing*, by Dr. M. Fishbein, formerly Editor of the *Journal of the American Medical Association*. The volume is obtainable from medical libraries in South Africa. It is published by the Blakiston Co., Philadelphia, U.S.A.

Papers submitted for publication in this *Journal* are accepted on condition that they have not been published elsewhere. The *Journal* Management reserves the copyright of all material published.

Considerable delay in the publication of papers is often due to the fact that they are poorly prepared. Publication will be expedited if the following specifications are complied with:—

1. All copy shoud be typewritten (double or preferably triple spaced) with wide margins.

2. Tables, references, graphs, illustrations and legends for illustrations should be clearly identified and *prepared on separate sheets*.

3. All photographs should be glossy prints unmounted, untrimmed and unmarked. Authors' suggestions for trimming, etc., are most suitably indicated on a duplicate print or diagram.

4. In no circumstances should original X-ray films be forwarded. Glossy prints must be submitted.

5. Line drawings should be on white board, arranged to conserve vertical space. All lettering in diagrams and graphs should be indicated clearly in soft lead pencil, preferably on a duplicate specimen or diagram in rough. In no circumstances should lettering be inked in or typewritten on the figure or the graph. Illustrations should not exceed 12 inches × 18 inches in size.

6. Figure numbers should be marked clearly on the back of each illustration, and in every case the top of the illustration should be indicated.

7. A limited but reasonable amount of illustrative and tabular matter is allowed free. Additional material of this sort may be allowed at cost, at the discretion of the Editor.

8. All references to the literature should be inserted in the text as a superior number and listed at the end of the article in numerical order.

9. References must conform to the following convention (journal titles being abbreviated according to the *World List of Scientific Periodicals*):—

White, J. and Brown, A. B. (1946): Arch. Clin. Med., **123**, 167.

Books should be cited as follows:—

Smith, J. (1946): *An Introduction to Medicine*, 2nd ed., p. 174. Cape Town: John Black, Ltd.

10. All numerals to be printed as figures (i.e. *not* spelt out). *For 'one' or 'l' always follow copy.* All numerals *always* to be spelt out in full at the beginning of a sentence.

11. Cubic centimetre *as* c.c.; Cubic millimetre *as* c.mm.; 7.11.46 *as* 7 November 1946; 2nd *as* second; 10/6 *as* 10s. 6d.; Per cent. *as* %; 1′ as 1 inch; B.P. 140/80 *as* Blood pressure, 140/80 mm. Hg.

12. Each paper should conclude with a summary (of about 200 words) intelligible apart from reference to the main text of the article.

13*a*. Galley proofs will be forwarded to the author in good time before publication date.

13*b*. Corrections, other than typographical errors, will be charged to the author. It is therefore most important that the MS. be submitted in its *final form*.

14. *Reprints:* An order blank for reprints, together with a price list, will be sent to the author as soon as his article reaches page-proof stage.

15. All manuscripts and correspondence should be addressed to:—The Editor, *The South African Medical Journal*, P.O. Box 643, Cape Town.

## IMPORTANT NOTICE

**Medical practitioners who intend applying for any appointment specified in this notice for which an advertisement appears in this issue of the Journal are advised to communicate first with the Honorary Secretary of the Branch of the Medical Association of South Africa concerned:**

***Advertisement:*** **Mines Benefit Society — Thoracic Surgeon.**

***Advertisement:*** **Transvaal Laundry, Dry Cleaning And Dyeing Workers' Sick Benefit Fund — Part-time Medical Officer.**

***Branch:*** **Southern Transvaal, M.A.S.A., 5, Esselen Street, Johannesburg.**

## Mines Benefit Society

### PART-TIME THORACIC SURGEON

Applications are invited for the position of part-time Consultant Thoracic Surgeon to the Society.

The conditions attaching to the appointment are as follows:

(*a*) The salary will be £2,500 a year.

(*b*) The successful applicant must be a Thoracic Surgeon registered with the South African Medical Council, and shall:

(i) provide his own consulting rooms and equipment;

(ii) attend cases referred to him by one or other Specialist Medical Officer of the Society.

(iii) Be allowed one month leave of absence each year but shall make arrangements at personal cost to the satisfaction of the Society for the performance of his duties during such absence.

(iv) Furnish such reports and returns as the Society may from time to time require;

(v) give the same consideration to members of the Society and their dependants as regards precedence of appointments as is given to private patients.

(*c*) The contract may be terminated by either party thereto at three months' notice.

Applicants should give the following information in writing, to be in the hands of the undersigned by the 20th December 1954: (i) age; (ii) professional qualifications; (iii) experience and particulars regarding appointments held at present or previously; (iv) the date on which duties can be commenced.

O. W. Johns
*General Secretary*

P.O. Box 8603,
Johannesburg
16th November 1954

### REGISTERED MEDICAL PRACTITIONERS

Applications are invited from registered medical practitioners for the purpose of examining new employees to a factory situated in Ndabeni. Attendance as required. Full particulars obtainable from the Personnel Manager, P.O. Box 1682, Cape Town. Closing date for applications 8th January 1955.

### MEDICAL OFFICER

Applications are invited from registered medical practitioners for the post of part-time medical officer to the Transvaal Laundry, Dry Cleaning and Dyeing Workers' Sick Benefit Fund. The successful applicant will be required to commence duties on 2nd January 1955, must be bilingual and willing to attend to European and Coloured members. Availability of consulting rooms in Bezuidenhout Valley, Johannesburg, will be a recommendation. Write P.O. Box 1609, Johannesburg.

## University of the Witwatersrand, Johannesburg

### MEDICAL SCHOOL

The undermentioned diploma course in the Faculty of Medicine may be offered in 1955:

### DIPLOMA IN PSYCHOLOGICAL MEDICINE

Applications should be lodged with the Assistant Registrar (Faculty of Medicine), Medical School, Hospital Hill.

The closing date for the receipt of applications for admission to the course is 10th January, 1955.

## Swaziland Government

### VACANCIES FOR MEDICAL OFFICERS

Applications are invited from registered medical practitioners for the above post on a salary of £865:865:935 × 35—1,005 × 45—1,140 × 45—1,320 per annum. In determining an officer's point of entry into this scale, credit may be given for war service and previous experience. Cost of living allowance is payable, and at present the rates are as follows:

Married Rates: On the first £800 of salary 19%; on the remaining salary 14%, with a maximum of £212 per annum.

Single Rates: One half of the above rates subject to a maximum of £106 per annum.

The post is pensionable and carries the usual civil service conditions and leave privileges, but contract appointments may be considered. Furnished quarters are provided by Government for which there is a rental deduction from salary of 10%.

Annual vacation leave (cumulative) of six weeks and two week's occasional (non-cumulative) leave are granted subject to the exigencies of the service.

Private practice is at present permitted, but an officer is not entitled as a right to practice on his own account.

Further particulars and forms of application may be obtained from the Director of Medical Services, P.O.Box 5, Mbabane, Swaziland.

## For Sale

### WATER STERILIZER 220-250 VOLT

One pair 6 gallon non-pressure sterilizer, 220-250 volt. Brand new. The reason for selling, too big for requirements and available electric current. Original cost, £127. Committee prepared to consider any reasonable offer. Apply to the Secretary, Richmond Private Hospital, Richmond, Cape.

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accurate and is presented without bias. Recent advances are presented along with the long-tested therapeutic methods, and caution is advised when these new methods have yet to prove their efficacy.

In a publication of this nature it is impossible to review each section in detail. Most physicians would applaud the practical manner in which the medical management of hypertension is handled but would be disappointed in the little recognition accorded to advances that have originated from European countries. The Lente Insulins and Largactil have been in use for more than a year but there is no mention of them in this publication. It is a pity too, that drug nomenclature conforms only to American standards, and apart from the diabetic section the lack of even a limited bibliography is often felt. These and other minor criticisms regarding dose schedules should not detract from the obvious advantages of possessing this as a quick and adequate reference volume for therapeutics. Anything that lessens the burden on the busy practitioner is welcome and this publication is recommended for that purpose.

B.B.S.

### INTERNAL MEDICINE

*Advances in Internal Medicine:* Volume VI. Edited by William Dock, M.D. and I. Snapper, M.D. (Pp. 375 with 98 illustrations. $10.00) Chicago: Year Book Publishers, Inc. 1954.

*Contents:* 1. Uropepsin. 2. Glucagon. 3. Diagnosis of Cancer of Internal Organs by Papanicolaou Technic. 4. Spatial Vectorcardiography. 5. The L.E. Cell Phenomenon. 6. Biopsy Studies of the Liver and Kidney. 7. Thrombotic Thrombocytopenic Purpura. 8. Porphyria. 9. Diaphragmatic Hernia. 10. The Determination of Insulin in Blood. Author. Index. Subject Index.

The signs of the times are clear in internal medicine. The physician of a generation ago examined his patient with his five senses and a stethoscope, aided perhaps by a few simple tests in the side-room. Today it seems that he must approach the bedside, if he does so at all, with a cathode-ray oscilloscope, a set of biopsy needles, and a preparation made from the diaphragm of a rat. It is useless to deplore the change; the new physician must know something of a large number of difficult and often obscure subjects, and he will find some of them well dealt with in this book. All the articles are informative and well documented.

Some interesting techniques are described. Needle biopsy of the kidney, though it frequently fails to produce satisfactory specimens, appears to be at any rate a reasonably safe procedure. It will obviously be useful if it can be made more reliable. Spatial vectorcardiography is incomprehensible to the reviewer, but apart from yielding information to the initiated it must impress the patient considerably. One or two of the articles, though authoritative and of great value to the specialist, are rather too detailed for the general physician for whom the book is presumably intended; but this is a fault in the right direction. The book is well produced and contains less than the usual quota of words like *pathoanatomic* and *miniaturize*. Both physicians and clinical pathologists should find it valuable.

P.B.

### DERMATOLOGY

*The Year Book of Dermatology and Syphilology* (1953–1954 *Year Book Series*). Edited by Marion B. Sulzberger, M.D. and Rudolf L. Baer, M.D. (Pp. 456, with illustrations. $6·00.) Chicago: The Year Book Publishers Inc. 1954.

*Contents:* Introduction. Some Advances in Dermatologic Management: A Guide for the General Practitioner. 1. Treatment and Prevention. 2. Eczematous Dermatitis, Atopic Dermatitis and Urticaria; Allergy. 3. Drug Eruptions. 4. Miscellaneous Dermatoses. 5. Cancers; Precancerоses; Other Tumors. 6. Fungous Infections. 7. Other Infections; Infestations. 8. Venereal Diseases and their Treatment (Exclusive of Gonorrhea). 9. Investigative Studies. 10. Miscellaneous Topics. Index.

The 1953–54 Year Book of Dermatology and Syphilology presents an excellent collection of abstracts from the literature and this volume is the better for the greatly increased number of contributions taken from continental European journals.

The Editors' chapter on 'Some Advances in Dermatologic Management' gives a good summary of recent advances and of reorientation on older remedies. They state: 'As was predicted in 1946, sulphonamides have been almost entirely abandoned as *topical* medicaments because of their allergenic sensitizing capacity and because of the advent of antibiotics with much broader antibacterial spectrums.' This prediction has not, unfortunately, been fulfilled in all countries.

Attention is drawn to the advantages of aureomycin, terramycin and chloramphenicol over penicillin for systemic therapy in infective skin diseases apart from trepanematoses and furunculosis; but the drawbacks of pruritus, monilial eruptions and gastro-intestinal upsets which may accompany their use are noted.

There are useful notes on the use of xanthotoxin (Ammi majus Linn.) in vitiligo, monobenzyl ether of hydroquinone in hyperpigmentations, and Atabrine and chloroquine in lupus erythematosus.

A pertinent note on fatty-acid preparations for fungous infections points out that their main advantages are in prophylaxis and in that they are safe weapons for the non-dermatologist because they rarely cause sensitization; the older remedies give better and quicker results.

The dental cartridge syringe is at last publicly recognized as a most useful instrument for the dermatologist.

J.M.

### PERIMETRY

*Perimetry.* Joshua Zuckerman, B.Sc., M.D., C.M., F.A.C.S. (Pp.391 + xxiv, with 156 illustrations. 80s.) Philadelphia; London; Montreal: J. B. Lippincott Company. 1954.

*Contents: Part I. Fundamentals in Perimetry.* 1. The Vocabulary and the Language of Perimetry. 2. Complex or Coupled Terms and Phrases (Arranged in the Same Sequence as Presented in the Previous Chapter). 3. Fundamental Concepts. *Part II. Perimetric Studies.* 4. Equipment. 5. Anatomy and Physiology. 6. Fields of Vision. 7. Procedure for the Examination of the Fields of Vision. 8. Lesions of the Choroid and the Retina and their Field Defects. 9. Glaucoma and its Field Defects. 10. Lesions of the Optic Nerve. 11. Lesions of the Optic Chiasm. 12. Lesions of the Optic Tract. 13. Lesions of the External Geniculate Body. 14. Lesions of the Optic Radiation. 15. Lesions of the Occipital Visual Cortex. 16. Non-organic or Functional Disturbances and Malingering. 17. Review of the Various Lesions and their Corresponding Field Defects. *Part III. Summary and Supplementary Data.* 18. Descriptive Review of Perimetry. 19. Tabular Review of Perimetry. 20. Defects which may be Encountered in Mapping the Field of Vision. 21. Trouble Spots or Tell-Tale Areas in the Field of Vision. 22. Pitfalls in Perimetry. 23. The Visual Fields in some General or Systemic Diseases. 24. Disturbances of Vision or of the Field of Vision Without External Evidence of Disease. 25. Mathematical Aids in Perimetry. Bibliography. Index.

A glance at the list of contents above will give a fair picture of the lay-out and presentation of this book.

'Where shall I begin', said the White Rabbit. 'Begin at the beginning, of course', said the King, 'and go on to the end; then stop.' The author has observed the wisdom of this advice, save that, having reached the end of each section, he has felt it necessary to go over it again in the form of a summary. Nor is this all, for if there is one thing for which this book is remarkable it is repetition. Professor Zuckerman does not repeat himself unwittingly, however, for in his preface he makes it clear that this is his intention. It is as if he found it necessary to drum facts in to immature and unwilling students—perhaps he does, but this realization can hardly endear him to his reader.

The logical approach is much stressed by the author. Indeed there can be no doubt of the logic and clarity of the whole presentation; on these grounds there is no fault to find—the work is admirable. It may be well to remember, however, that perimetry relies entirely upon a subjective response which all too frequently ignores logic.

Chapter I commences with the assumption that the reader knows nothing; from this zero mark it moves purposefully and logically forward, save for the frequent backward step to stress a point previously explained at length until, after some 50 pages, the 'vocabulary and language' of the subject has been covered; and so it goes on.

I was brought up to think of the visual field as an island in a sea of darkness and am, not surprisingly, unwilling to change it for a fertile valley in an arid desert; but the one concept is doubtless as useful as the other. Much is made of the Zuckerman cross as a means of following the fibres from retina to cortex; it is difficult perhaps to judge its merit for clarity of understanding unless one is studying the subject for the first time.

The third innovation is the Zuckerman code for marking isopters; this is perfectly adequate, but if logic is the order of the day why not use coloured pencils for colour fields, instead of dots and dashes?

However, these criticisms, dealing, as they do, with the technique of presentation must not be allowed to detract from the excellence of the work as a whole. It is easy to read, well printed and with good diagrams; clear, if not concise; and, it may be stated again, covers its subject completely.

S.C.A.

PHYSICAL TREATMENT IN PSYCHIATRY

*An Introduction to Physical Methods of Treatment in Psychiatry*. By William Sargant, M.A., M.B. (Cantab.), F.R.C.P. and Eliot Slater, M.A., M.D. (Cantab.), F.R.C.P. Third Edition. (Pp. 351 + xix. 20s.) Edinburgh: E. & S. Livingstone, Ltd. 1954.

*Contents:* 1. The Insulin Treatment of Schizophrenia. 2. Modified Insulin Therapy. 3. Convulsion Therapy. 4. Treatment of the Epilepsies. 5. Chemical Sedation and Stimulation. 6. Continuous Sleep Treatment. 7. The Use of Drugs in Psychotherapy. 8. Diet, Vitamins and Endocrines. 9. Prefrontal Leucotomy. 10. The Treatment of General Paralysis. 11. The Treatment of Alcoholic Addiction. 12. The Relation of Psychological to Somatic Treatment. Bibliography. Index.

This, the 3rd edition, of Sargant and Slater's book is a valuable contribution to psychiatric literature. Each chapter leaves the reader in no doubt that the views expressed therein are based on an extensive practical experience associated with keen powers of observation. In spite of the close attention to detail given to the various intricate treatments described, the authors have managed to present their material in an easily readable form. The theme which permeates the entire book is well exemplified by quoting from the introduction the following few sentences 'It is only a sign of our infantile dependence on authority, when we tolerate the existence of rigidly dogmatic schools. If we permit the claim that there is only one treatment, whether this be psychotherapy or E.C.T., for every kind and condition of psychiatric illness, we set our feet on a slippery path. The step that inevitably follows is contempt for diagnosis or for any objective examination, as irrelevancies, and a religious fervour in which reason and self-criticism are submerged. Scientific progress then stops'.

About a third of the book is devoted to an account of insulin treatment and of convulsive therapy, given with a wealth of detail, out of which most psychiatrists will certainly extract much that is informative and which certainly will prove a reliable guide to those in the earlier years of their psychiatric work. Your reviewer is disappointed in the attitude of the authors towards electro-narcosis and their failure to describe this method of treatment in detail because 'it is doubtful whether its effects are different from E.C.T. followed by non-convulsive stimulation'. (A recent publication in this *Journal* presented this form of treatment in a much more favourable light.)

The rewritten section on prefrontal leucotomy presents a well-balanced view of this much discussed operation, and makes it abundantly clear that neuro-surgery has much to offer in suitably chosen cases of mental illness. The authors' opinions concerning the selection of the most promising type of patient for this type of treatment are clearly set out and, backed as they are by a post-operative history of 10 years or more in many cases, obviously valuable. The new section devoted to the treatment of alcoholic addiction describes some of the more recent chemical methods but, in spite of the title of the book, makes it clear that these are not likely to give the best results without the aid of the psychotherapeutic approach, social measures, occupational readjustment etc.

This book can be highly recommended to medical practitioners interested in the treatment of mental illness and certainly should occupy a place on the bookshelves of those practising psychiatry.

G.J.K.

PROCTOLOGY

*Manual of Proctology*. By E. Granet. (Pp. 346. $7.50.) Chicago, U.S.A. Year Book Publishers, Inc. 1954.

*Contents:* 1. Anatomy. 2. Anorectal Symptoms, Examination, and Diagnosis 3. Anesthesia. 4. General Therapy. 5. Pediatric Proctology. 6. Pyogenic Infections of the Anorectum. 7. Anal Fissure. 8. Haemorrhoids. 9. Benign Tumors. 10. Malignant Tumors. 11. Ulcerative Colitis. 12. Specific Infections of the Anorectum. 13. Pruritus Ani. 14. Proctalgias and Anorectal Dyscrasias. 15. Prolapse. 16. Diverticula of the Colon. 17. Pilonidal Disease. 18. Miscellany. Index.

This instructive book, obviously prepared by a well-informed author, presents a comprehensive coverage of the subject scaled down in an extremely modest manner.

The introductory chapters are on the approach to proctology, and emphasize fundamentals of anatomy, physiology, symptoms, examination and diagnosis. There follow chapters on fissure and haemorrhoids, embodying all that is best from both sides of the Atlantic. There is an interesting account of the crypts and the part they play in the formation of abscess and fistula, and Goodsall's stitch is described, with indication of its use for ligaturing broad-based haemorrhoids—a considerable aid in avoiding mucosal stenosis when both primary and secondary haemorrhoids have to be dealt with in the one pedicle. More emphasis might have been placed on the avoidance of skin stenosis both at and after operation.

Benign tumours are very well covered and, with malignant tumours, the indications for the various procedures are discussed without too many technical details. Hartmann's operation is explained, and might well be given its place again, especially in the senile debilitated individual. There are good chapters on ulcerative colitis and specific infections of the ano-rectum and an excellent chapter on pruritus ani that speaks volumes for the author's experience with this difficult subject. In conclusion, prolapse is well covered and there is a detailed chapter on pilonidal disease.

For a book written in a general practice series, Dr. Granet is to be congratulated on his handling of this extremely important subject and on the production of a book that will be of the greatest value to all practising medical men.

A.B.

DERMATOLOGY

*Aids to Dermatology*. By Robert M. B. MacKenna, M.A., M.D., B.Chir.(Camb.), F.R.C.P.(Lond.) and E. Lipman Cohen, M.A., M.B., B.Chir.(Camb.). Fourth Edition. (Pp. 296+viii, with 5 illustrations. 7s. 6d.). London: Baillière, Tindall & Cox. 1954.

*Contents:* 1. Introductory: Anatomy and Physiology. 2. Some Congenital Abnormalities of the Skin. 3. Diseases Caused by Pyogenic Cocci and Certain Other Bacteria. 4. Diseases of the Skin Associated with the Sebaceous Glands 5. Diseases Caused by Animal Parasites. 6. Diseases Caused by Fungi. 7. Tuberculosis, Leprosy, Cutaneous Leishmaniasis. 8. Eczema and Eczematous Eruptions. 9. Drug Eruptions. 10. The Lichens. 11. The Erythemata. 12. The Urticarias. 13. Virus Diseases. 14. Dermatitis Herpetiformis and Pemphigus. 15. Pityriasis. 16. Psoriasis, Parapsoriasis. 17. Pruritis, Prurigo. 18. Purpura. 19. Tumours of the Skin. 20. Sclerodermia, Scleredema, Sclerema, Poikiloderma. 21. A Group of Miscellaneous Diseases. 22. Diseases and Abnormalities of the Hair, Nails and Sweat Apparatus. Index.

It is a great pleasure to welcome the 4th edition of Aids to Dermatology by MacKenna and Cohen. In the 8 years since the last edition, dermatology has made the same striking advances that are characteristic of medicine generally. This has been emphasized in the new edition, and many chapters have been revised. The text includes material on the uses of antibiotics and hormones, as well as the various chemotherapeutic treatments for tuberculous disease of the skin. On the diagnostic side can be found Tzanck's test for the bullous disorders, and the 'L.E. phenomenon' in acute disseminated lupus erythematosus.

In these days the average practitioner has so much to read, that a volume such as this with a vast amount of material very succulently provided in a small compact mass is of considerable value. I am sure that this book will have the popularity amongst practitioners and students which it well deserves.

R.L.

ADVANCES IN DERMATOLOGY

*Recent Advances in Dermatology:* Second Edition. By W. Noel Goldsmith, M.A., M.D.(Cantab.), F.R.C.P.(Lond.) and Francis F. Hellier, O.B.E., M.A.(Cantab.), M.D., F.R.C.P.(Lond.). (Pp. 461+x, with 5 illustrations. 42s.) London: J. & A. Churchill, Ltd. 1954.

*Contents:* 1. Metabolism. 2. Vascular Disorders. 3. The Collangenoses. 4. Nervous and Psychological Influences. 5. Endocrine Glands. 6. Vitamins. 7. Affections of the Reticular Tissue. 8. Allergy. 9. Fungous Infections. 10. Virus Diseases. 11. Industrial Dermatitis. 12. Radiant Energy. 13. Miscellaneous. 14. Therapeutic Agents. Index.

The dermatological world will welcome the 2nd edition of this book; the 1st edition appeared as far back as 1936 and hence the present production covers nearly 2 decades of development in the speciality. This interval permits widening of perspective and enables a better evaluation of progress to be made than can be made by a study of the journals or even the year-book. Text-books, on the other hand, however up-to-date, cannot, because of exigencies of

space, present all the different points of view on which a conclusion is reached and so tend to be dogmatic.

The intimate relationship between general medicine and dermatology is evident from the study of the collagen diseases. Systemic lupus erythematosus frequently occurs without any cutaneous manifestations; another name needs to be found for it, and the descriptive term 'capillaritis generalisata maligna' has the authors' support.

From the list of the chapters given above it is clear that most of the field is dealt with; it is a pity that malignant diseases of the skin are not more fully discussed. They play too important a part in a dermatologist's life to be so slighted.

This book is primarily intended for, and will be best appreciated by, those who have already a knowledge of dermatology and have an interest in its many-sided problems. The very latest views on the uses and abuses of hormones, antibiotics, antihistamines, etc. will interest the general physician and student. Although this is not a text-book, the average reader would prefer to find a clinical description of a rare condition such as 'impetigo herpetiformis', in addition to a discussion, however interesting, of its etiology and treatment.

The few colour-plates and illustrations are well up to modern standards. An ample list of references concludes each chapter.

Drs. Goldsmith and Hellier are to be congratulated on the skill and care so clearly demonstrated in every paragraph of their book, which for many years will be recognized as standing at the pinnacle of post-war dermatological literature.

J.J.J.

### HEBREW PHILOLOGY

*Wonderful Words: The Development of the Meaning of Hebrew Antonyms Derived from a Common Root. A Study in Countersense.* By Ben Morrison, M.D., F.R.C.S.(Ed.). (Pp. 556+xxi. 42s.). Johannesburg: City Book Agency (Pty.), Ltd. 1954.

*Contents:* 1. Foreword; The Origin and Purpose of this Book; History of Countersense; Abbreviations; Bibliography; Glossary of New Coinage and Uncommon Expressions. 2. Polarity in General; Polarity in Language; Psychological Theories Advanced to Explain Polarisms. 3. The Linguistic Approach to Polarics; Nomenclature; Method and Principles of Research; Classification of Polarisms. 4. Introduction to Gesturisms. 5. Introduction to Empirikisms; Analysis of Empirikisms. 6. Introduction to Mental-Echoisms; Analysis of Mental-Echoisms. 7. Consonance of Sounds. 8. Introduction to Comparative Sonitisms. 9. Introduction to the Prosthetic Nun in the Formation of New Root-Words; Analysis of New Root-Words Resulting from the Addition of Prosthetic Nun. 10. Hebrew Metatheses; Introduction; Mental-Echoisms; Triple Anagrams; True Polarisms; Neutral Anagrams; Analysis of the More Important Anagrams; Analysis of 48 Possible Transpositions; 11. The 3 Classes of Polarisms Compared; The Immediate Mechanism of the Linguistic Approach to Polarics. 12. The Law of Antithetical Potentials. 13. Exegetical Studies.

Dr. Morrison is a Johannesburg medical practitioner who has taken an interest in the study of semantics. From the above resumé of the contents it will be clear that he is especially interested in a phenomenon, known to students of Semitic languages, whereby the same words sometimes have opposite meanings.

The author has gathered a vast amount of material from the vocabulary of the Hebrew language. He classifies the words and offers explanations for the development of different meanings. The problem is approached from the linguistic and psychological angles and an effort is made to ascertain the most primitive meanings. His terminology at first seems strange, for he coins his own terms to describe the various classes of words, but this is no drawback, since one soon gets used to them.

Some of his theories seem highly probable and deserve serious attention. Among other things he emphasizes the role played by gestures in the original meaning of verbs denoting movement, and by similarity in sound between different roots. The peoples of the ancient Near East were very fond of playing with words, and this may have had greater influence on the development of meanings than has hitherto been recognized.

Dr. Morrison has put a great amount of work and thought into this stimulating book, to which he has devoted 14 years of his spare time. In reading the book one cannot help noticing that the author's knowledge of medicine has been drawn upon in explaining certain words. It would be interesting to know whether his colleagues agree with his conclusions. It is to be hoped that students of Semitic languages will be stimulated to undertake further research in connection with this very interesting subject.

P.F.D.W.

### PAEDIATRICS

*Recent Advances in Paediatrics.* Edited by Douglas Gairdner, D.M., F.R.C.P. (Pp. 470+x, with 117 illustrations. 42s.). London: J. & A. Churchill, Limited. 1954.

*Contents:* 1. The Establishment of Respiration. 2. Prematurity. 3. Perinatal Mortality. 4. The Care of the Newborn Infant. 5. Haemolytic Disease of the Newborn. 6. Infant Feeding. 7. Oesophageal Atresia. 8. Hiatus Hernia. 9. Hirschsprung's Disease and Other Causes of Chronic Constipation. 10. Gastro-Enteritis. 11. Immunization Against Infectious Disease. 12. Coeliac Disease. 13. Fibrocystic Disease of the Pancreas. 14. Intersexuality and the Andrenogenital Syndrome. 15. Sudden Death in Infancy. 16. Tuberculosis. 17. Some Metabolic Disorders. 18. Congenital Heart Disease. 19. Cerebral. 20. Nurture and Mental Development. Index.

This book, under the editorship of one of Britain's junior-senior paediatricians, is a mine of information on the subjects shown in the list of contents. The articles are not 'snippets' of information but miniature reviews covering aetiology, clinical manifestations, pathology and treatment of the respective subjects with a commendable balance between erudition and the requirements of the clinician. Each section is covered in 20-30 pages, illustrated by tables, charts and photographs and accompanied by an extensive bibliography which, in many instances, brings the information up to the current year. The print is very legible, the illustrations excellent, and the index adequate if somewhat abbreviated.

The book is certain to be in demand by those whose special interest is paediatrics; it would also be a valuable investment for general practitioners, since text-books having reached an almost prohibitive price, there are very few books which supply so much recent information on so many subjects at the moderate cost of this one. There is an unusually practical approach to each problem which should be of great assistance to practitioners who, in South Africa, are liable to be located at very long distances from possible expert consultations.

The first quarter of the book is concerned with neonatal problems of almost as much importance to the obstetrician as to the succeeding paediatrician or general practitioner, and would be a valuable addition to their reference libraries.

An admirable adjunct to our bookshelves.

F.J.F.

### OPERATIVE GYNAECOLOGY

*Textbook of Operative Gynaecology.* Wilfred Shaw, M.A. (Camb.), M.D., F.R.C.S.(Eng.), F.R.C.O.G. (Pp. 444+ix, with 382 illustrations. £5). Edinburgh and London: E. & S. Livingstone, Limited. 1954.

*Contents:* 1. Preoperative Preparation. 2. Anaesthesia in Gynaecological Surgery; Instruments, Needles, Technique. Blood Transfusion. 3. Anatomical Considerations. 4. Opening and Closing the Abdomen. 5. Postoperative Treatment and Complications. 6. Abdominal Hysterectomy for Non-Malignant Conditions. 7. Abdominal Hysterectomy for Myomata: Myomectomy. 8. Treatment of Carcinoma of the Uterus. 9. Treatment of Retroflexion of the Uterus. 10. Surgery of the Ovary: Ovariotomy. 11. Surgery of Inflammatory Conditions of the Uterine Appendages. 12. Surgical Treatment of Endometriosis. 13. Operative Treatment of Ectopic Pregnancy. 14. Operations for Sterility. 15. Sterilization Operations. 16. Operations on the Sympathetic Nerves. 17. Vaginal Hysterectomy for Non-Malignant Conditions of the Uterus Unassociated with Prolapse. 18. Operative Treatment of Prolapse. 19. Operations for Rectovaginal Fistula and for Complete Lacerations of the Perineum. 20. Operations for Imperfect Control of Micturition (Stress Incontinence). 21. Operations on the Cervix. 22. Operations on the Cavity of the Uterus. 23. Surgical Treatment of Diseases of the Urethra and Vagina. 24. Surgery of the Vulva. 25. Surgical Treatment of Urinary Fistulae. 26. Treatment of Operation Wounds of the Bladder Ureter and Intestine. 27. Non-Gynaecological Conditions Found at Operation. 28. Caesarean Section and Anterior Hysterectomy. 29. Termination of Pregnancy in the Early Weeks; Vaginal Hysterotomy; Vaginal Methods of Sterilization. Index.

This large 28-centimetre book represents British medical publication at its best. It is a work of great excellence and beauty, and publishers and author are both to be congratulated on their production. One feels proud and gratified that we now have a British book on Operative Gynaecology that can hold its own with its German and American contemporaries.

There are 382 illustrations, of which only a few are in colour. These are all of a very high artistic standard and anatomical accuracy. The objective was to make a primary feature of the drawings; and for this purpose the author followed the plan of taking photographs and then making a drawing, both of these serving as a prototype for his artist, Mr. Leslie Caswell. The Viennese artist Erich Lepier has produced a few of the illustrations, and some are actually made from the original pictures loaned by the publishers of the Peham-Amreich text-book.

The book is a pleasure to handle and grows on one, and the reviewer believes that the courage of author and publishers has been well rewarded. The late Mr. Wilfred Shaw has honoured his school at St. Bartholomew's Hospital by writing it and has left a monument to his memory. The book will long be used by post-graduates in training, and it will not require frequent new editions.

It contains what is best in British gynaecological surgery. Shaw is an individualist, and has the courage of his convictions. Although he had his main training in Vienna and is particularly well informed about what has been written on the subject, he is manifestly and pre-eminently English—and for this reason alone his book will find a place in our treasure house. The opinions and methods set out are very sound, although on a few trivialities the author is peculiarly obstinate.

On the literary side he is experienced and mature, and his artistic merit is of a high order. The gynaecological firmament is mainly dark, but such glimmerings as exist are due to occasional lights on the horizon like Wilfred Shaw. He could so easily have been greatly distinguished, but he was obviously under the thrall of the tradition of his own hospital and of authoritarianism in general. He would have been a great anatomist and pathologist in his field had he disregarded the cosmos and its unfilled lamps. As it is, we have as author a thoughtful anatomist and pathologist, an intellectual, a scholar, and an artist.

If a second edition one day appears, it is recommended that the chapter on ectopic pregnancy be extended. This is a very important subject, and those for whom the book is especially written require instruction in it. Further, Shaw has obviously a limited experience in advanced ectopic pregnancy, malignant ovarian disease, vesico-vaginal fistula, and vaginal hysterotomy. Sections like these might be written with more conviction and with less attention to what the multitude may think. Similarly the servile attitude to such ancillary personnel as physicians and anaesthetists is not in the best interests of the patient, nor does it become the surgeon.

O.S.H.

### FRAZER'S EMBRYOLOGY

*Frazer's Manual of Embryology*. By J. S. Baxter, M.A., M.Sc., M.D., F.R.C.S.I. (Pp. 488+ix with 288 Figures. 42s.). London: Baillière, Tindall and Cox, Ltd. 1953.

*Contents. Part I. Early and General Development.* 1. Development, Sex-cells, Fertilization, Sex Determination. 2. The Ovarian and Uterine Cycles. 3. Segmentation of Fertilized Ovum. 4. Review of the General Conditions which will be reached by the Ovum in its Development. 5. Embedding of Ovum and Early Stages of its Development. 6. The Embryonic Plate: Mesoderm and Notochord. 7. Formation of Somites and Intra-Embryonic Coelom. 8. The Yolk-Sac. The Establishment of a Circulation. 9. General Growth Throughout Intra-Uterine Life. 10. Formation of Placenta and Foetal Membranes. *Part 2. Development of Separate Organs and Regions.* 11. The Vertebral Region and Body Wall in General. 12. The Nervous System. 13. Spinal and Cranial Nerves, Sympathetic, Olfactory Bulb, Eye, and Inner Ear. 14. General Account of the Fore-Gut. 15. Derivatives of the Primitive Pharynx. 16. Formations on the lower Side of the Projecting Head. Face, Mouth, Nose, and Base of Skull. Outer Ear. 17. Development of Skull and Teeth. 18. Development of the Heart, and Vessels of the Anterior Part of the Embryo. 19. Thorax. General Considerations. 20. The Fore-Gut Above and Behind the Septum Transversum, with the Structures Developed from and in Association with it. 21. The Abdominal Cavity in General. The Dorsal Wall and Structures placed there. 22. Development of Mid-gut and Hind-gut. 23. Infra-Umbilical Region of Abdominal Wall, Cloaca and its Derivatives. Genital System. 24. Integument and Associated Structures. Development of Limbs. Index.

When first published in 1931, Frazer's Manual of Embryology represented a major contribution to British embryology. Its attainment of a 3rd edition (in 1953) is adequate testimony to its popularity and the need it still serves amongst English-speaking students. During the last decade, it has contested position with other valuable embryological texts, notably those of Arey and of Hamilton, Boyd and Mossman.

To cover important advances in our knowledge concerning the earliest stages of development resulting from work by Hertig and Rock, Heuser, Streeter and other embryological stalwarts the present author, Dr. Baxter has almost completely rewritten part I. Despite revision, however, we still miss the fine photomicrographs of very young embryos that are found in other text-books; a lack emphasized by the indifferent quality of many of the pen illustrations.

Part II on the other hand has received very little alteration; the original observations of the late Professor Frazer remain virtually unchanged. Almost a quarter of a century has elapsed since he first set on record his observations; and, at that time, his manner of presenting his data was both novel and useful. In the interim, important advances have been made in understanding the course of development in the various organs of the embryo, particularly the urinogenital complex, about which the present author is silent. Indeed, it becomes doubtful whether the revision can justify its claim to have preserved the original character of the book, namely, to give a connected picture of the developing embryo, when recent work in the field covered by Part II is omitted.

The manual has a good index but unfortunately there is no bibliography. This is a serious drawback to any serious student who desires to consult the sources upon which the author's statements are based; it is a matter that should receive attention in any future edition so that the valuable standards originally set by Professor Frazer in his first manual will, if anything, not only be maintained but transcended.

C.G.

### MEDICAL EMERGENCIES

*Emergencies in Medical Practice*. By C. Allan Birch, M.D., F.R.C.P. Fourth Edition. (Pp. 610+xii with 143 illustrations. 32s. 6d.) Edinburgh: E. & S. Livingstone Ltd. 1954.

*Contents:* 1. The Emergency Bag. 2. Acute Poisoning. 3. The Hazards of Medical Procedures. 4. Acute (Non-Surgical) Abdominal Catastrophies. 5. Other (Non-Surgical) Abdominal Emergencies. 6. Medical Emergencies in Obstetrics and Gynaecology. 7. Respiratory Emergencies. 8. Cardio-Vascular Emergencies. 9. Emergencies in Blood Diseases. 10. Fits, Faints and Unconsciousness. 11. Neurological Emergencies. 12. Psychiatric Emergencies. 13. Medical Emergencies in Diabetes. 14. Medical Emergencies in other Endocrine Disorders. 15. Medical Emergencies in Renal Disease. 16. Medical Emergencies in Infancy and Childhood. 17. Emergencies in Infectious Fevers. 18. Emergencies in Tropical Medicine. 19. Emergencies in Industrial Medicine. 20. Medical Emergencies at Sea. 21. Medical Emergencies in the Air. 22. Ophthalmic Emergencies. 23. Emergencies in Skin Disease. 24. Emergencies during Anaesthesia. 25. Post-Operative Medical Emergencies. 26. Bites and Stings and Miscellaneous Emergencies. 27. Medico-Legal and other Non-Clinical Emergencies. 28. Practical Procedures. Appendices I-V.

This remarkable book contains considerably more than its title implies—it describes the treatment of almost every imaginable medical emergency in far greater detail than the usual text-book of medical treatment, and in addition gives guidance to the practitioner on the management of an extraordinarily wide variety of 'difficult situations'.

A few examples of subjects discussed are: Medical causes of acute abdominal pain, medical emergencies in obstetrics and gynaecology, problems arising out of travel by sea and air, conflicts which may arise between ethics and the law, how to remove a fixed wedding ring. There are many others, and it is difficult to think of an urgent problem which is not included—although it may not always be easy to find in the index. The subject matter is well written and for the most part completely up-to-date.

This book can be recommended with little reservation as one which every general practitioner should carry in his bag or motor car.

M.J.B.

### BILHARZIA

*An Introduction to Molluscan Ecology*. By Alan Mozley, D.Sc., PH.D., F.R.S.E. (Pp. 71+x, with 15 illustrations. 9s.) London: H. K. Lewis & Co. Ltd. 1954.

*Contents:* 1. Distribution and its Limits. 2. Living Conditions. 3. Representative Populations. 4. Dangerous Localities. 5. The Local Economy. 6. Practical Considerations. 7. Conclusion. Appendices. Index.

The author has followed up the publication in 1944 of *The Control of Bilharzia in Southern Rhodesia* by a series of booklets on the bilharzia problem. The present booklet is the fourth. Eventually maybe they will be rewritten and combined in one volume, but in the meantime separate publication in sequence helps to keep the problem alive.

Effective means of controlling the snails which carry the bilharzia parasite are now known, and the author insists on the urgency of utilising these practical and comparatively inexpensive methods at the present time and without cessation.

The present book, especially chapter 6 and appendix C, is a pointer for the intensive study of the habitats of the snails, with a view to proceeding in due course from the stage of controlling, and to some extent preventing, bilharziasis to extirpating it.

Concise descriptions are given of the life-cycles of the bilharzia parasite and the liver-fluke.

K.H.B.

### FLUID THERAPY IN INFANTS

*Practical Fluid Therapy in Pediatrics*. By Fontaine S. Hill, M.D. (Pp. 275+xx, with 20 figures. $6·00.) Philadelphia and London: W. B. Saunders Company. 1954.

*Contents:* Section I. *Basic Physiologic Principles and their Clinical Significance.* 1. Role of Water in Body Physiology. 2. Normal Electrolyte Composition of Blood Plasma, Interstitial Fluid, Intracellular Fluid, and Gastrointestinal Secretions. 3. Abnormalities of Electrolyte Patterns. 4. Renal Regulation of Fluid and Electrolyte Balance. 5. Dehydration and Water Intoxication. Section II. *Diagnosis and Treatment of Clinical Conditions.* 6. Solutions for Parenteral Administration. 7. Diarrhoea. 8. Diabetic Coma. 9. Fluid Therapy in Renal Disease. 10. Pyloric Stenosis and Nonobstructive Vomiting. 11. Fluid Therapy in Acute Infections. 12. Salicylate Poisoning. 13. Fluid Therapy in Surgical Conditions. 14. Fluid Therapy in Burns. 15. Respiratory Acidemia and Alkalemia. Section III. *Technical Procedures.* 16. Techniques for Obtaining Blood Specimens. 17. Techniques for Parenteral Fluid Administration. Bibliography. Index.

Knowledge of the physiology of water and electrolyte metabolism is essential for the proper planning of parenteral fluid therapy. This applies particularly to paediatrics, where improper or insufficient attention to hydration can have disastrous results in a large variety of illnesses.

This book is useful in that it presents clearly and in an easily assimilable form, current concepts of normal and abnormal fluid and acid-base balance. Much information that could otherwise only be obtained from extensive reading of monographs, textbooks and journals is included in the text. The author has necessarily had to be dogmatic on certain controversial aspects to avoid confusion in a work that is essentially practical, but his recommendations are in general sound and comprehensive.

Insufficient stress is laid on the danger of giving hypertonic solutions to small infants. In dealing with intestinal obstruction more emphasis might have been placed on the accurate measurement of fluids aspirated by suction drainage. This allows for more efficient replacement of losses *via* this route. In several instances concurrent administration of subcutaneous fluids when an intravenous drip is already running is advocated. This would seem to complicate treatment unnecessarily, and is uncomfortable for the patient.

A useful glossary giving definitions of biochemical terms is included and the photographic illustrations of practical procedures are good. This book should contribute a great deal to the dissemination of essential knowledge in an important subject, and can be recommended to student and doctor alike.

J.H.

### FLUID AND ELECTROLYTE THERAPY

*Fluid and Electrolyte Therapy*. Franklin L. Ashley, B.S., M.S., M.D. and Horace G. Love, B.S., M.D. (Pp. 72. 24s.) Philadelphia; London; Montreal: J. B. Lippincott Co. 1954.

*Contents:* 1. Introduction. 2. The Action of the Various Systems and Organs Aiding in the Maintenance of a Stable Body Reaction and Fluid Balance. 3. Function of the Kidneys in the Maintenance of Electroneutrality in the Extracellular Fluid. 4. Water Balance. 5. Fluid Therapy in Children. 6. Fluid and Electrolyte Therapy in the surgical Patient. 7. Fluid and Electrolyte Therapy in the Recently Traumatized Patient. Index.

The purpose of this book is to present to students and housemen in simple form the fundamental principles of fluid and electrolyte therapy. No one will doubt the importance of this, and if anyone can succeed in condensing this complex subject clearly and reliably into 60 small pages he will put us all in his debt.

But these authors do not succeed. Such a primer must be accurate and intelligible. For inaccuracy we need only read as far as page 5, where to clarify the concept of milliequivalents we are told that a solution containing 12 mg. of magnesium per litre has a milliequivalence of 2 and in the next sentence that it has a cation concentration of 1 m.eq. This contradiction is not in itself important, but it is only the first example showing how little care has been taken to make the details of the book reliable. Under gastro-intestinal control of fluid balance we find this: 'Nitrogen retention occurs in large fluid losses when an insufficient quantity of water remains in the lower bowel to excrete solid waste products.' What on earth does this mean? Probably not constipation, as I thought on first reading.

If the authors will correct their mistakes, clarify their text and reduce their price their book would serve a very useful purpose.

G.C.L.

## CORRESPONDENCE : BRIEWERUBRIEK

### ACCIDENTS

*To the Editor:* The editorial[1] on accidents in the issue of 13 November was most opportune.

Relentlessly, death takes its toll on the roads, families are deprived of their breadwinners, untold sorrow and misery caused. This appalling waste of life, limb and money is as you state, Sir, preventable.

'Courtesy weeks' and exhortations to 'drive safely' are futile. If this rising tide of road accidents is allowed to go on unabated the consequences will be disastrous. A long-term policy to combat this scourge would be to make Traffic and related problems bearing on road accidents, a subject at all our schools—European and non-European.

Immediate action should be demanded by all responsible bodies and public-minded citizens, and this to be in the form of much more drastic and summary action against road offenders. Punishment is much too lenient, and one gets the impression that liquor and dagga offences are regarded as more dangerous, to judge by the punishment meted out.

It is high time we realized that the careless or dangerous driver is a potential murderer, and as anti-social as any criminal.

G. Apostolides

'Riversmead'
P.O. Izotsha
S. Coast
9 December 1954

1. S. Afr. Med. J., **28**, 966.

### THE DECLINE AND FALL OF THE GENERAL PRACTITIONER

*To the Editor:* Much has been written lately about the difficulties which beset the medical profession and how the specialist is intruding more and more into the family doctor's sphere. Many think this is the cause of all the trouble, but it would be wrong to blame this one factor alone for what is happening and what is the result of a general change in the conditions of life and practice.

When I was young the general practitioner was really a recognized factor in the family life. He was the man to whom one turned not only in bodily sickness but also in other troubles. He was the tried and trusted friend of the family. He was regarded as a person of the highest standing, as one whose single-minded aim was to help the suffering, and, at least subconsciously, as one with mysterious knowledge and powers.

In those days it was easier than today for one man to cover the whole field of medicine, and the need for specialists seemed to be less. If the G.P. did not quite see his way, he consulted a specialist, but this did not happen very often. A good G.P. handled by himself most of the ailments presenting themselves in his practice. Indeed he would have lost prestige had he called in the specialists too often. Today the patient or his family takes the lead in calling in the specialist, or goes to him even before a G.P. has been consulted. Too much stress should not be laid on the fact that the public is allowed to consult a specialist without first calling in a G.P.; where is human freedom if even in disease a person is not allowed to turn to whom he pleases for help?

One of the causes of the change in attitude to the general practitioner is the perpetual 'scientific' articles in the public press. The patient of today often thinks he knows as much as the doctor, and he even offers the doctor advice. This upsets the whole doctor-patient relationship. The doctor, on his side, is beginning to lose confidence in himself. He fears to lose his patient if he does not adopt any whim or any new fashion in medicine which may turn up. Drugs and other remedies the patient has read or heard about he agrees to prescribe even if he is not convinced that they will do any good. By this course he loses not only his own self-respect but his influence upon his patient.

Publicity has an important influence on the relationship between doctor and public; yet the doctors themselves are not altogether innocent of the glaring headlines of the newspapers; mostly some medical 'expert' is behind the articles. While publicity may serve a good purpose by teaching hygienic knowledge, e.g. about the prevention of infectious disease, it sometimes passes all bounds and misleads the public or causes panic. When the public press fails to provide the patient with all the knowledge he thinks he needs for the diagnosis and treatment of his disease he will read up his case in a text-book (a famous clinician used to warn these patients to be careful, they might die of a misprint).

Yet, at the same time, the patient wants to feel that his particular case is his doctor's chief interest. This appearance is impossible if the doctor has 2 or 3 consulting rooms in distant parts of the town, where he attends daily as well as visiting his bedridden patients at home and at nursing homes. So many doctors seem to be always on the run, and while entering the sickroom seem to be leaving it again. Such a doctor does not bring rest and quiet to the disturbed patient but restlessness and anxiety; and he seems to have no time for proper consideration of the case.

Before the world wars life in general was easier and doctors were less concerned with the financial aspect of their practice. The constant raising of medical fees has only made the public run to hospitals and clinics which, originally meant for the needy, are taking more and more patients away from the private practitioner. Other patients seek the shelter of benefit societies, from which the profession is much concerned to exclude the higher-income groups.

While competition becomes fiercer the profession seems to attract a growing number of recruits whose urge to study medicine is not directed mainly by idealistic and altruistic motives, but the desire to provide themselves with a rich income.

It seems that the only way out of this dilemma will be State medicine. If a doctor is guaranteed a reasonable income, medicine will cease to appear as the business proposition which it threatens to become. There will perhaps be fewer doctors, but this will do no harm to the profession as such; and there is no reason why a medical man should not be esteemed by the public and trusted as highly as a judge is today, and the medical profession regain some of its old splendour which, at the moment, it is rapidly losing.

J. F. Salinger, M.D.

148 St. George's Street
Cape Town
10 December 1954

### POLIOMYELITIS

*To the Editor:* Poliomyelitis is known to occur in epidemics during the late summer and early autumn; it is relatively commoner amongst the well-to-do Europeans in South Africa than amongst the indigent Natives; and it is spread by carriers of the poliomyelitis virus *via* faeces and fingers and food handled by them.

I think that the correlation of these facts may indicate why poliomyelitis occurs at the above-named season, and why it is relatively commoner amongst the European, with their higher incomes and different tastes, than amongst the Natives.

In the late summer and early autumn there is an abundance of fresh fruits and salad foods such as tomatoes and lettuce, which are not cooked before being eaten; and when these foods have been infected with the virus by carriers they will convey the disease to the consumers. Europeans eat far more of these foods than the Natives do.

These facts, I think, should be carefully considered by those who are investigating the spread of poliomyelitis and by those who are responsible for protecting the public against the disease.

It would seem advisable to cook all foods before consumption in areas where poliomyelitis has occurred, and not to eat uncooked fruits and salads, even although they have been brought from areas far removed from the scene of the outbreak of poliomyelitis. Such foods may be contaminated by carriers where they are grown and picked or during their conveyance to the consumers.

F. A. Lomax

Johannesburg Building Society Buildings
91 Cross Street
Kroonstad
9 December 1954

### NATIONAL CANCER FUND

*To the Editor:* The attention of members of the Medical Profession is directed to an article which appeared on page 907 of the *South African Medical Journal* dated 23 October 1954.

Following the lead of several other countries, the National Cancer Association of South Africa was established in December 1931 in pursuance of a unanimous solution taken at a Union-wide Cancer Conference at which the Medical Association of South Africa was represented.

A second Union-wide Cancer Conference in which the Medical Association of South Africa again participated, resolved in July 1951, to establish a National Cancer Fund to further the objects of the National Cancer Association.

To combat cancer in South Africa, the closest co-operation of the medical profession is essential and it is the desire of the National Cancer Association to keep as far as possible the profession informed of all developments.

The National Cancer Association makes a special appeal to all members of the Medical Profession to generously support the National Cancer Fund and assist where possible, local committees of the Appeal Organisation.

Cheques for donations should be made payable to 'The National Cancer Fund' and sent to P.O. Box 2000, Johannesburg.

Lewis S. Robertson
*President*
*National Cancer Association of South Africa*

### A DISCLAIMER

*To the Editor:* Recently there appeared in the press an article on a patient Mr. Riell Muller, and later a large number of circulars were sent out to professional and business men, appealing for donations to a fund on his behalf.

At the end of this circular, the names of two doctors were given, and it was stated that they could be approached to give further information.

These two doctors wish it to be known that their names were introduced without their knowledge and consent, and that they were not consulted as to the arrangements which, it seems, are being made for the further treatment of the patient.

A. H. Tonkin
*Secretary (M.A.S.A.)*

9 December 1954

### DIARREE BY JONG KINDERS EN BABETJIES

*Aan die Redakteur:* Die artikel '*The Treatment of diarrhoea in young children and infants*' van 4 deser deur dr. Frank Rousseau[1] bevat 'n paar interessante opmerkings.

Ek kan die rationale van sy beleid verstaan waar hy kaolin-preparate afkeur waar dit verstopping met die gevaar van toksemie sal veroorsaak. As 'n mens kaolin egter nie in te hoë dosisse gebruik nie of as die etiese preparate na gelang van die ouderdom van die kind verdun word met water (soos ek dikwels gedoen het) kan ek nie die gevaar van skielike verstopping sien nie. Die mortaliteit in gastro-enteritis in kinders is meestal a.g.v. dehidrasie en elektrolite-verlies en maar selde te wyte aan toksemie.

Waar ek egter hoegenaamd nie saamstem met dr. Rousseau nie is by sy gebruik van kasterolie. In ons verligte eeu is daar seer sekerlik beter en minder drastiese middels om te gebruik. Ek stem ook nie saam met die prinsiep van purgeermiddels in gastro-enteritis nie. Om daardie geïrriteerde, rooi, geswelde, ge-inflammeerde derm mucosa nog verder te prikkel met purgativa lyk nie vir my rasioneel nie, veral in 'n baba wat 10-12 stoelgange op 'n dag passeer het. Ek dink die volgende keer wat dr. Rousseau gastro-enteritis kry kan hy gerus een of 2 eetlepels kasterolie neem en voel hoe dit is om 'n derm wat reeds vol koliek en hiperperistalse is nog erger koliek en peristalse te gee met kasterolie.

Ek sal seer sekerlik iemand wat my kind, met gastro-enteritis, kasterolie gee, beskou as aandadig aan aanranding met die doel om ernstige liggaamlike letsel te berokken.

J. G. Prinsloo

Pk. Marikana
Dist. Rustenburg
9 Desember 1954

1. Rousseau, F. (1954): S. Afr. T. Geneesk., **28**, 1038.

# The Medical Association of South Africa
# Die Mediese Vereniging van Suid-Afrika

## AGENCY DEPARTMENT : AGENTSKAP-AFDELING

### DURBAN

112 Medical Centre, Field Street. Telephone 2-4049

### PRACTICES FOR SALE

**(PD28)** Durban. General practice, also non-European surgery. Owing to ill-health owner wishes to sell as soon as possible. Premium £1,750. House for sale £8,000.

**(PD30)** Durban. Old-established good class, mainly European practice. Premium £3,000. Owner intends specializing.

**(PD31)** Natal Inland. Unopposed prescribing practice, mainly Native. Monthly cash receipts average £450. Premium required £2,500 includes surgery, furniture and instruments. House for sale. All sporting facilities.

**(PD32)** Northern Natal. Well established general mixed practice of 20 years standing. M.O.H. and D.S. appointments. All hospital facilities. Premium £1,500 including surgery furniture and drugs. House £12 per month. For immediate sale.

### SPECIALIST PHYSICIAN

Physician Specialist unopposed practice for immediate sale. Inland City Premium £2,500 includes £1,000 equipment.

### ASSISTANTS REQUIRED

**(NC5)** Assistant required in general practice, country practice. 75% non-European. No surgery or midwifery undertaken. Very little night work. Commence December 1954. Salary £1,200 p.a. ½-hour drive from Durban.

**(SM12)** Assistant with view to partnership from 1/1/1955. Must be bilingual. East Griqualand. Salary to be discussed.

### LOCUMS REQUIRED

**(WA9)** Locum required from 1 February for one month. £3 3s. 0d. per day, all found, plus car allowance. Practically no night work. Zululand.

**(SV5)** Locum for January or earlier. £3 3s. 0d. per day, all found. £10 car allowance and petrol. Natal Hospital town. Travelling allowance to and from practice for reasonable distance.

Locums and/or assistants are urgently required for urban and rural areas. Details on application.

* * *

### KAAPSTAD : CAPE TOWN

Posbus 643, Telefoon 2-6177 : P.O. Box 643, Telephone 2-6177
Waalstraat 35 : 35 Wale Street

### PRAKTYKE TE KOOP : PRACTICES FOR SALE

**(1834)** Oostelike Provinsie. Dorp met hospitaalfasiliteite en geleentheid vir snykunde. Bruto inkomste 1954—£5,200. Uitgawes laag. Ryk woldistrik. Koopprys van £2,000 sluit spreekkamermeubels in maar nie medisyne nie. Uitstekende huis te koop indien verlang vir £4,200. Verband teen maklike terme vir £3,400 beskikbaar.

**(1760)** Cape Town Suburb. Average annual cash takings £3,442. Scope for surgery, premium £1,750. Payment on terms to be arranged. Considerable discount for cash.

**(1771)** Groot plattelandse hospitaaldorp. Eenmanspraktyk. Koopprys £1,000 vir klandisiewaarde, geneesmiddels, instrumente en apteekameublement. Gerieflike moderne huis te koop teen £4,500. Betaling kan in paaiemente geskied. Goeie vooruitsigte.

**(1716)** Cape Province. Town with Provincial hospital. Gross receipts, 1953/54, £6,900/£6,400. D.S. appointment. House for sale or to let. £3,000 required for goodwill. Payment ± £1,000 cash, balance over 3 years. Seller would consider any reasonable offer as he wishes to specialize.

### OPHTHALMIC PRACTICE FOR SALE

**(1325)** Excellent practice with two appointments.

### ASSISTENTE/PLAASVERVANGERS VERLANG
### ASSISTANTS/LOCUMS REQUIRED

Locums and/or Assistants are urgently required for urban and rural areas. Details on application.

### CONSULTING ROOMS AVAILABLE

**(1422) (1579)** in Cape Town. Available on temporary or permanent basis. Full use or to share.

### SPECIALIST PHYSICIAN

(a) Specialist practice offered for sale. Details on application.
(*b*) Required to act as locum in this practice for 3 months from June 1955.

* * *

### JOHANNESBURG

Medical House, 5 Esselen Street. Telephones: 44-9134/44-0817
Mediese Huis, Esselenstraat 5. Telefone: 44-9134/44-0817
Tel. Ad.: 'Serpent'

### PRACTICES, PARTNERSHIPS AND ASSISTANTSHIPS
### PRAKTYKE, VENNOOTSKAPPE EN ASSISTENTSKAPPE

**(718)** Northern Rhodesia. A Locum is required for a couple of months, to be paid the best of terms—with view to assistantship *or* partnership, with or without capital. One of the most promising Rhodesian practices. To start beginning January 1955.

**(720)** Southern Rhodesia. An Assistant is required to start as soon as possible. If suitable a Partnership will be offered. Car not essential. This is a partnership practice.

**(727)** Northern Transvaal Hospital Town. An Assistant is required for a very old-established practice, with appointments. If suitable a Partnership will be discussed.

**(729)** Oos-Transvaal. 'n Assistent word benodig vir 'n baie groot vennootskappraktyk, met groot aanstellings. Verkieslik iemand met vorige ondervinding. Geen hospitaalgeriewe. Na twaalf maande van indiensneming sal 'n Vennootskap aangebied word.

**(Pr-S161)** Noord-Vrystaat. 'n Derde vennoot word verlang in 'n ou gevestigde praktyk. Verkieslik iemand met vorige ondervinding. Om te begin 1 Februarie 1955. Geleentheid vir snykundige werk.

**(Pr-S160)** Transvaal Town, near Johannesburg. A well-established practice is for sale for £250. Drugs and furniture to be taken over at valuation. Long introduction will be given. Easy terms will be arranged.

**(Pr-S158)** Noord-Transvaal. 'n Jong, maar puik praktyk word te koop aangebied, teen £750. Maklike terme sal gereël word. Bruto-inkomste van afgelope jaar was £3,600. Distriksgeneesheersaanstelling. Die praktyk is geleë in 'n baie vooruitstrewende area. Geen ander geneesheer. Moontlike koper kan dadelik 'n plaasvervanging doen, om die praktyk deur te kyk.

**(Pr-S155)** Noord-Vrystaat. 'n Helfte aandeel in 'n vennootskappraktyk word te koop aangebied. Hierdie tweemans-praktyk is ongeopponeerd. Die maandelikse bruto-inkomste is oor £600. Premie van £750, is betaalbaar as volg: £250 kontant en balans teen £25 per maand.

**(Pr-S130)** Reef Hospital Town. A well-established practice with an appointment, is for sale at the low premium of £1,500. Easy terms arranged. Excellent scope for Afrikaans speaking doctor, interested in surgery. Also scope for a non-European branch.

### INTERNIS : VENNOOTSKAP

**(Pr-S159)** 'n Gulde geleentheid vir 'n Internis (nie geregistreerd) om 'n vennootskap te bekom, in 'n uitmuntende vennootskappraktyk, in groot Transvaalse hospitaaldorp. Volle besonderhede op aanvraag.

### INSTRUMENTS FOR SALE

Siemens Heliosphere X-ray, complete with screen. Price £300 or nearest offer.

Diathermy—Birtcher Challenger—good condition. Price £130 or nearest offer.

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### MINE MEDICAL OFFICER

A vacancy exists for an Assistant Medical Officer at a large mine hospital in the Klerksdorp district. Chamber of Mines conditions. Apply giving details of qualifications, experience, age, marital state, etc. to A.X.L., P.O. Box 9421, Johannesburg.

# Transvaal Provincial Administration

## VACANCIES : TRANSVAAL PUBLIC HOSPITALS

Applications are invited from suitably qualified candidates for the undermentioned posts at Public Hospitals in the Transvaal.

Applications should be addressed to the Medical Superintendents of the undermentioned Hospitals concerned and should contain full particulars as to the age, professional and academic and language qualifications, experience and conjugal status of the applicant and should further indicate the earliest date upon which duties can be assumed. Copies, only, of recent testimonials to be attached.

Cost of Living Allowance payable at present to full-time employees:

| *Salary* | *Cost of Living Allowance* | |
|---|---|---|
| | *Married* | *Single* |
| Over £350 p.a. | £352 p.a. | £110 p.a. |

Full-time employees receive in addition to their salaries and cost of living allowance, the following privileges:

Leave and rail concession.

Successful candidates will be required to submit satisfactory certificates as also to submit to a medical examination at the hospital concerned.

Application forms are obtainable from any Transvaal Provincial Hospital or the Provincial Secretary, Hospital Services Branch, P.O. Box 2060, Pretoria.

The closing date of applications for undermentioned posts will be 12 January 1955.

| *Post* | *Hospital* | *Salary* | *Qualifications and Remarks* |
|---|---|---|---|
| Junior Specialist (Medicine) | Pretoria | £1,200×50—1,500 | Registered Medical Practitioner with higher qualifications in Medicine. |
| Part-time First Assistant Dermatologist | Johannesburg Hospital and the University of the Witwatersrand | £135 p.a. 1 session per week | Registered Medical Practitioner. Higher degree in Medicine a recommendation. |
| Part-time Second Assistant Dermatologist | Johannesburg Hospital and the University of the Wit-watersrand (2) | £100 p.a. 1 session per week | Registered Medical Practitioner. Higher degree in Medicine a recommendation. |
| Part-time Chest Physician | Boksburg-Benoni | £615 p.a. 3 sessions per week | Registered Medical Practitioner. Qualified chest physician. To be in charge of unit but falls under the Head of the Department of Medicine. |
| Part-time Thoracic Surgeon | Boksburg-Benoni | £615 p.a. 3 sessions per week | Registered Medical Practitioner. Qualified Thoracic Surgeon. To be in charge of unit in collaboration with the Head of Department of Surgery. |
| Part-time General Practitioners | Witbank (2) | £510 p.a. 3 sessions per week | Registered Medical Practitioner. |
| Anaesthetic Registrar | Johannesburg Hospital and the Witwatersrand University | £620—780—820—860 | Registered Medical Practitioner. |
| Clinical Assistant | Vereeniging | do. | Registered Medical Practitioner. Must be qualified for at least 2 years. |
| | Warmbaths Non-Acute | do. | do. |
| Clinical Assistant (Anaesthetics) | Vereeniging | do. | do. |
| Medical Officer | Far East Rand, P.O. New State Areas | £620—780—820—860 | Registered Medical Practitioner. |
| Casualty Officer | Far East Rand, P.O. New State Areas. | £620—780—820—860 | Registered Medical Practitioner. |
| Senior Housemen | Far East Rand, P.O. New State Areas | £480 p.a. Plus board and quarters or an allowance of £120 p.a. in lieu of board and quarters | do. |
| | Vereeniging (2) | do. | do. |
| *Or* | | | |
| Intern | Far East Rand, P.O. New State Areas | £240 p.a. Plus board and quarters or an allowance of £120 p.a. in lieu of board and quarters | — |
| | Vereeniging (2) | do. | — |

48506

## WANTED : SPECIALIST ANAETHETIST

Wanted: Specialist Anaethetist to act as locum in large coastal town, period minimum six months commencing 1 March 1955. Good prospects of permanency. Reply A.X.I., P.O. Box 643, Cape Town.

# Chamber of Mines (Springkell) Sanatorium

## MEDICAL OFFICER

Applications are invited for the following post which will fall vacant in February, 1955.

1. Junior Resident Medical Officer (Intern) at a salary of £26 per month less £11 per month for board and quarters plus cost of living allowance of approximately £22 per month.

OR

2. Resident Medical Officer at a salary of £644 per annum less £144 per annum for board and quarters plus cost of living allowance of approximately £22 per month.

Further information from: The Medical Superintendent, Springkell Sanatorium, P.O. North Rand, Transvaal. Telephones: 45-2244/5.

## Public Service Vacancies

1. The attention of Medical Practitioners and Dentists registered with the South African Medical and Dental Council is drawn to an advertisement appearing in the *Government Gazettes* of the 17th, 24th and 31st December, 1954, inviting applications for the undermentioned posts in the Public Service.

| *Post* | *Salary Scale* | *Department or Administration* |
|---|---|---|
| Dental Inspector of Schools (Transvaal Education Department) | £1,020×60—1,200 | Transvaal Provincial Administration. Closing date: 29 January 1955. |
| Medical Inspector (Bloemfontein) | £1,380 | Health |
| District Surgeon, Grade III (Pretoria and Pietermaritzburg. | £1,020×60—1,380 | Health. |
| Medical Officer (Ovamboland, S.W.A.) | £1,020×60—1,380 | South West Africa Administration. |
| Works Supervisor (Johannesburg) | £894×42—1,020 | Pensions: Closing date: 31 January 1955. |
| Medical Officer (Bulwer) | £1,020×60—1,380 | Health. |

2. In addition to salary a cost of living allowance at the rate of £234 per annum is at present payable to married officers.

3. It is emphasised that full particulars of qualifications and experience must be furnished but original certificates and testimonials should not be submitted. Application forms (Z. 83 and P.S.C. 8 (8)) are obtainable from the department/administration indicated to whom completed forms must be addressed.

4. The closing date for the receipt of applications is 15 January 1955, except where otherwise indicated.

48599

## Provinsiale Administrasie van die Kaap die Goeie Hoop

**UNIVERSITEIT VAN KAAPSTAD : GESAMENTLIKE MEDIESE PERSONEEL VIR GROOTE SCHUUR EN ANDER OPLEIDINGSHOSPITALE**

**VAKATURE**

1. Aansoeke word ingewag van geregistreerde Geneeshere (geregistreerde Spesialiste) vir aanstelling tot die volgende pos:

*Gesamentlike Patologiese Diens.* Geneesheer, Graad F, Patoloog, met salaris teen £1,800 per jaar (vasgestel).

2. Benewens die salaris soos aangedui is 'n lewenskostetoelae betaalbaar aan voltydse beamptes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word.

3. Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens, no. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

4. Van die Gesamentlike Mediese Personeel word vereis om die Provinsiale Administrasie van die Kaap die Goeie Hoop en die Universiteit van Kaapstad gesamentlik te dien.

5. Kandidate moet nie minder as drie jaar ondervinding na registrasie as 'n Spesialis in die spesialiteit waarin die vakature bestaan, opgedoen het nie.

6. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23), wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal, of by die Sekretaris van enige skoolraad in die Kaapprovinsie.

7. Die ingevulde aansoekvorms moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word, en moet hom uiters op 8 Januarie 1955 bereik.

M.129358

## Provinsiale Administrasie van die Kaap die Goeie Hoop

**HOSPITAALDEPARTEMENT**

**VAKATURES: MEDIESE PERSONEEL**

Aansoeke word ingewag van geregistreerde geneeshere vir aanstelling vir 'n tydperk van 1 jaar, onderworpe aan verlenging na verstryking van die voormelde tydperk tot die volgende poste op die personeel van die Provinsiale Hospitaal, Port Elizabeth.

| *Pos* | *Emolumente* |
|---|---|
| Geneesheer, Graad B | £720×40—960 p.j. |
| Geneesheer, Graad A (3 poste) | £500—600—660—720 p.j. |

Benewens die salarisskaal soos aangedui, is 'n lewenskostetoelae betaalbaar aan voltydse beamptes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word. (Die teenswoordige tarief is getroude mans £352 per jaar andere £110 per jaar).

Die voorregte van vry kos, inwoning en klerewas is nie aan hierdie poste verbonde nie.

Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens no. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

Die pligte van die bekleër van die pos van Geneesheer, Graad B, sal soos volg wees:

1. Om in die hoedanigheid van senior ongevalle en snykundige beampte waar te neem.
2. Om toesig oor die werk van interns te hou.
3. Om die behandeling van siek verpleegsters waar te neem.
4. Om sodanige administratiewe pligte as wat deur die Mediese Superintendent aan hom toevertrou word, uit te voer.

Van die bekleërs van die poste van Geneesheer, Graad A, sal verwag word om hoofsaaklik in een van die volgende hoedanighede waar te neem maar boonop sal ook van hul verwag word om sodanige pligte as wat deur die Mediese Superintendent aan hul toevertrou word uit te voer:

(*a*) Narkotiseur.
(*b*) Verloskundige.
(*c*) Ortopedis.

Aansoeke moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrygbaar is by die Mediese Superintendent van die Provinsiale Hospitaal, Gipsonweg, Port Elizabeth, aan wie die aansoeke gestuur moet word om hom nie later as 30 Desember 1954, te bereik nie.

M.129359

## Village Management Board of Touws River

**PART-TIME MEDICAL OFFICER OF HEALTH**

Applications are invited for the abovementioned post at an honorarium of £60 p.a. and will be received by the undersigned till 3 p.m. on 7th January, 1955.

H. V. Whitwam
*Secretary*

508 Nataid House
14 Plein Street
Johannesburg

## Dorpsbestuur van Touwsrivier

**DEELTYDSE MEDIESE GESONDHEIDSAMPTENAAR**

Aansoeke vir die bovermelde betrekking teen 'n honorarium van £60 p.j. word gevra en sal deur die ondergetekende tot 3 nm. op 7 Januarie 1955 ingewag word.

H. V. Whitwam
*Sekretaris*

Nataid-gebou, 508
Pleinstraat 14
Johannesburg

## Provinsiale Administrasie van die Kaap die Goeie Hoop

### HOSPITAALDEPARTEMENT

### HOSPITAALRAADSDIENS: VAKATURES

Aansoeke word ingewag van geregistreerde geneeshere vir aanstelling tot die volgende vakante poste:

| *Afdeling* | *Pos* | *Hospitaal* | *Emolumente* | *Sluitingsdatum* |
|---|---|---|---|---|
| Professionele en Tegniese | Geneesheer, Graad A | Livingstone-hospitaal, Port Elizabeth | £500–600–660–720 p.j. | 6.1.55 |
| | do. | Victoria-hospitaal, Lovedale | do. | — |

Aansoeke moet aan die Mediese Superintendent van die betrokke hospitaal gerig word.

Die diensvoorwaardes word voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens no. 19 van 1941, soos gewysig, en die regulasies wat daarkragtens opgestel is.

Benewens die salarisskaal soos aangedui is 'n lewenskostetoelae betaalbaar aan voltydse beamptes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word.

Die geslaagde kandidate, indien nie reeds in die Hospitaalraadsdiens nie, moet bevredigende geboorte- en gesondheidsertifikate indien.

Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrygbaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinsie.

Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar.

M129372

## South African Council for Scientific and Industrial Research

### BURSARY FOR RESEARCH INTO CAUSES OF ANAESTHETIC DEATHS

Applications are invited from medically qualified persons for a bursary of £1,200 to undertake full-time research into the causes of anaesthetic deaths. Transport and subsistence will be provided when necessary. Bursary is initially for one year but may be renewed for a further two years. The bursar will work mainly in Pretoria and Johannesburg. Experience in anaesthetics and/or pathology will be a recommendation.

Applications, giving full information, including publications or previous research work, to reach Secretary/Treasurer, C.S.I.R., P.O. Box 395, Pretoria, by 15 January 1955. 46852

## Suid-Afrikaanse Wetenskaplike en Nywerheidnavorsingsraad

### BEURS VIR NAVORSING NA OORSAKE VAN NARKOSESTERFGEVALLE

Aansoeke word ingewag van gekwalifiseerde medici vir 'n beurs van £1,200 om voltydse navorsing na die oorsake van sterfgevalle onder narkose te onderneem. Wanneer nodig, sal vervoer en verblyfkoste betaal word.

Die beurs is in die eerste instansie vir een jaar maar mag vir 'n verdere twee jaar hernu word. Die beurshouer sal hoofsaaklik in Pretoria en Johannesburg werk. Ondervinding van narkose en/of patologie sal 'n aanbeveling wees.

Aansoeke waarin volle besonderhede, insluitende publikasies of vorige navorsingswerk, vermeld word, moet die Sekretaris/Tesourier, W.N.N.R., Posbus 395, Pretoria, teen 15 Januarie 1955 bereik. 46852

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